

2nd
Edition

Health Seeking Behaviour of Rajbanshi Community



Nawa Raj Subba

**Health Seeking Behaviour of the Rajbanshi community
in Baijanathpur and Katahari of Morang Nepal**

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SECOND EDITION

ADJUSTING THE FIRST PUBLISHING

The research on Rajbanshi's health-seeking behaviour provides a window into Nepal's public health. This Rajbanshi ethnicity is one of the indigenous people of Nepal and is involved in modern and traditional medical practices. It also captures Nepal's entire ethnic diversity.

The public health and development field has read and supported this study, conducted almost two decades ago, with great interest. I once more revised this study material as though it were a master's thesis. I made grammatical corrections to it. To improve the presentation, I made some adjustments. It is hoped that this research will mark a turning point in the study of public health, social development, and culture, providing a foundation upon which future research into and evaluation of this community or region will be meaningful.

This author is still researching the Rajbanshi people's social and public health. After a certain period, the goal is to conduct a comparative study based on the findings of this study. As a result, this material may be helpful to both the reader and the researcher. With this in mind, I've included some of the revised second rites that were generally edited in the first edition.

Thank you once more to researcher guide Prof. Ritu Prasad Gartaula, and everyone acknowledged in the first edition. I took one of the pictures with the sunflower background for the book cover. For this, I also believe Ryan Tasto/Unsplash. Thanks.

Dr. Nawa Raj Subba

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SUMMARY

Nepal is a country of multi-cultural, multi-religious, multi-lingual, pluralistic and mosaic society. Ethnic communities have their distinct healing practices. It has been widely felt that access to modern medication in rural as well as in urban communities is very low; despite the service, outlets have been made available even at the periphery level by the government. Health Care practices - Modern, Traditional, Self-medication, and Alternative are existed in almost every community and are an indispensable part of our health system. Merely establishment of Sub-Health Posts and training for Health Workers cannot ensure access to health services, and also requires an attempt on the Socio-economic assessment and cultural and behavioural diagnosis.

Rajbanshi is one of the ethnic groups, living in Morang and Jhapa districts in Nepal. Their estimated population is fairly above 0.1 million (CBS, 1991). This study was an exploratory, descriptive, cross-sectional, and qualitative study based on a household survey. The study has assessed the disease prevalence, healing or caring practices and determinants of health-seeking behaviour.

This study was undertaken in two Village Development Committees (VDC) of Morang district in 2001 with the Specific objectives of: (1) to find out the practices of using traditional and modern medicine in the community. (2) Assess the satisfaction and dissatisfaction with traditional medicine and modern medicine or health services available. (3) Assess the expenses on health care. (4) Know various methods of self-care and types of therapies used by consumers. Attempts to 175 households' visits were made particularly the head of the households as respondents of the study. A Rajbanshi graduate and one more interviewer were trained before going to the community. With the help of these two-trained interviewers, the researcher carried out interviews and conducted Focus Group Discussions.

Major findings

Rajbanshi ethnic in Katahari and Baijanathpur VDC were found to have a literacy rate of 65% in the taken sample. The principal occupation is agriculture. The majority of people fall in the category of having no land to less than 2 bighas. The average family size is 5.76 persons. Attempts to interview mostly heads of the 175 households were made in two VDCs. And there were 61% of males and 39% of females reported sick.

A proportion percentage of the common type of ailments was reported such as headache, body aches, weakness (50.8) and then ARI (44), fever (30.8), Eye/ENT(18.8), and diarrhoea (13.7) were reported respectively. Distribution of reported illness was highest among those over 66 years of age than among 55-65 and 46-55 years of age respectively. People were found adopting Modern medication, Self-medication and Alternative-medication. Dhami Jhakri/Shaman, retailers were common practices under self-medication. 72.0% of patients used private clinics whereas only 15.4% of patients had used health post-service.

Poor were adopting self-medication higher than other economic strata were found statistically significant ($P=0.0160$). Similarly, the rich were adopting alternative medication more than the poor which was statistically highly significant ($P=0.0000$). Uneducated people used self-medication more than educated that was found statistically highly significant ($P=0.0000063$).

An average treatment cost has been found Rs. 1031.64 ($SD=6$). 73.1% of patients were reporting to be unable to afford the expenses for treatment. They had taken either loans (14%) or had to sell land, animals, grains or personal belongings (53%). The bulk proportion (57.8%) of expenses fell on buying drugs and for fees (19.55%) thereafter, for transportation 5%, helper 3.74%, and others 13.84%. Therefore, the concern about the unaffordability of treatment costs for modern medication is striking.

Utilization of PHC services: They were found familiar to go to EPI-Camp (79.4%) for getting a vaccination for their children. They are also familiar with FCHV and recognize her services. Most of the people know their FCHV (50.2%) and used to take service from her. On the other hand, more than 89.2% population was found still unknown to MCHW, TBA and PHC-ORC and its services.

Cost: The proportion of people paying between Rs.51-200 was 39% of the sample. But the average expenditure per patient was Rs. 1031.64 (i.e. mean, and $SD=6$) for a treatment. It is unaffordable for 73.2% of people; so, they take either loan or sell their belongings to accomplish the treatment.

Most of the proportion of their expense goes to buying drugs and paying fees. The rest portion was expensed for transportation, helper cost and others.

Satisfaction: Rich were found satisfied with alternative medication that was found statistically significant (0.0050). Educated were also found satisfied with alternative medication that was statistically highly significant ($P=0.0000$).

Recommendations

Based on the findings, the following recommendations could be made as follows: Since the majority of the poor people go for self-medication and the private clinic was perceived to be expensive; the personnel of the self-medication or service providers such as Dhami/ Jhakri/ Shaman, the retailer need to be oriented on a referral system. Since 73.2% of people are unable to afford treatment; free mobile health camps should be provisioned for the poor.

Since 89.2% of the population was unknown to MCHW, TBA and PHC-ORC services; training and awareness programs should be given to both service providers and users.

Abbreviations

CBS = Central Bureau of Statistics.
DDC = District Development Committee.
DPHO = District Public Health Office.
Dist. = district
DJ = Dhami Jhakri
EPI-Camp = Extended Program on Immunization camp.
FCHV = Female Community Health Volunteer.
HMG = His Majesty's Government.
HP = Health Post.
HW = Health Worker.
ILO = International Labour Organization.
IMR = Infant Mortality Rate.
IPs = Indigenous People.
LE = Life Expectancy.
MCHW = Maternity and Child Health Worker.
MOPE = Ministry of Population and Environment.
MLD = Ministry of Local Development.
MMR = Maternal Mortality Rate.
NGO = Non-governmental Organization.
NIPs = Non- Indigenous people.
PHC = Primary Health Care (centre).
PHC-ORC = Primary Health Care Out Reach Clinic.
SHP = Sub- Health Post.
TBA = Trained Traditional Birth Attendants.
THW = Traditional Health Worker.
UNICEF = United Nations Children Fund.
UNO = United Nations Organization.
VDC = Village Development Committee.
VHW = Village Health Worker.
WHO = World Health Organization.

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CHAPTER – I INTRODUCTION

1.1.Introduction and Background.

Access to modern medication in the rural community is very low, even though the government provides several service outlets. The Government of Nepal has attempted service deliveries through extensive outlets for periphery people. But many questions arise about quality, access to service and acceptance of services. Merely establishing health institutions and training health workers cannot ensure health service without assessment of their socioeconomic status and cultural and behavioural diagnosis. Since a complete health system approach has not yet been considered, any progress report published by the government or NGO cannot reflect a health system's holistic situation since traditional medicine exists in all cultures to a degree, and terms such as traditional medicine, indigenous medicine or folk medicine etc. These are used to describe Local practices. These medicine dates hundred or even thousands of years, depending on the country and culture concerned because two-thirds of the world's population (mainly in developing countries) relies entirely on such Traditional medical therapies and the WHO has declared its intention actively to encourage Traditional medicine worldwide so that they can attain the goal of Health for all.

Interestingly, even where western medical care is available, most people in the third world remain loyal to its indigenous medical systems, and the WHO promotes a realistic view of conventional medicine. She is assessing its advantages in light of contemporary science. She discourages harmful practices and encourages beneficial ones, fostering the integration of knowledge and skills that have been demonstrated to be valuable in both traditional and western medicine. A WHO report indicated for far too long traditional systems of medicine and modern medicine had gone their separate ways in mutual antipathy.

While explaining the worldwide prevalence of Alternative Medications, Agarwal (n.d), in his book A Guide to Alternative Medicine,

states that two-thirds of the world's population is still being treated by traditional health workers, especially in underdeveloped and developing countries, according to the estimate of the WHO. Considering the importance of these practices, the WHO has recognized their value and included these in their ongoing programs to achieve the goal of "Health for All."

Nepal is a country situated between China and India. It is brick-shaped, east-west length is 885 Km and North-South means the width of 193 Km. Its total area is 147181 sq. Km. The total population of Nepal in 2000 was 229,03,598 (MOPE). Nepal has got topographically three belts upper Mountainous, middle Hill and lower Terai regions extending east to west. Despite being small in area and population, there is wide variation socially, culturally and geographically. Due to geographical reasons, there is less access to health services in remote areas.

Nepal has a population of 20 million (1996), steadily growing at 2.1% annually. There is the world's highest mountain towering above-populated valleys, Himalayas and plains. It is a landlocked country, bounded to the north by the Tibet region of the People's Republic Of China and to the southeast and west by India. There are more than 75 ethnic groups religiously consisting of Hindus (89.5%) and Buddhists (5.3%), Jain (0.1%), Christians and others (0.23%). The different ethnic groups have their dialects. However, Nepali is the Lingua franca. Nepal is one of the least developed countries, with per capita income ranging from US\$ 180 to 200 per annum. A severe shortage of basic requisites such as sanitation, sanitation, safe drinking water, appropriate nutrition and health services characterizes the existing health situation. Immunization coverage is low; there is a high unmet demand for family planning services/ devices, and several epidemics and diseases have led to a high rate of morbidity and mortality in the country. The life expectancy at birth is around 55 years (HDR1998), IMR is 79/1000 LB, MMR 539/10000 LB, CMR 118/1000 LB, TFR 4.6 per woman, CBR 42/1000 population, CDR 13.3/1000 population (CBS, 1995, NFHS, 1996).

Modern health facilities provided by HMG/N are grossly inadequate, especially in areas of difficult terrain due to roads and shortages of medical and paramedical staff. According to the reports of DoHS 1998, there are 3187 SHPs, 764 HPs, 11 Zonal Hospitals, 14 DPHOs, 61 DHOs, 117 PHCs/HCs, and 155 Ayurvedic clinics. Besides, there are 894 doctors, 1220 nurses, 42427 FCHVs, 12682 TBAs and more than 4000 VHWs. Some of the districts out of 75 are without district hospitals, and the performance of SHPs and HPs, and PHCs delivery in the rural areas is far

from satisfactory. The utilization rate of SHPs and HPs is averaging 0.2 visits per person per year (Asima, 1991). There is, thus, clearly a gap to be filled up. The population will visit conventional traditional health practitioners or private drug retailers for their needs. Due to these circumstances and doctor-patients uncontrolled ratio, the doctor could not provide efficient services. Thus patient satisfaction is not found satisfactory.

Kafle and Gartaula (1993) have pointed out that developing countries have insufficient financial means to purchase drugs, and frequency management and healthcare infrastructure are less than adequate for the availability of essential drugs in rural areas. As a result, people have to rely on the health care system and herbal medicines, where these are still available. Nepal is no exception to the above. Due to financial limitations, the government-owned pharmaceutical organization is unable to ensure an adequate supply of allopathic drugs throughout the year. Public healthcare institutions are estimated to provide less than 20% of rural healthcare. Most of the year, people are thus forced to turn to the market for their health care. It consists of drug shops and various types of practitioners of traditional medicine (Ayurvedic, Chinese, Homeopathic etc.). Also included in this category are spiritual practitioners such as shamans, priests, Dharmi/Jhakris and astrologers. People can also use herbal medicines (roots, grasses, plants etc.), which they can collect in the forests or purchase from practitioners or shops.

There are many communities, strata of society or groups of people and Indigenous people who are still far from access to health services in remote and urban areas as we know that socioeconomic, cultural, genetic as well as educational factors determine the Health of people. Therefore there are a variety of disease prevalence and health-seeking behaviours of different groups of people in the country.

Gartoulla (1998) wrote a book entitled Therapy pattern of conventional medicine with other Alternative Medication. He found that Alternative medication practices in Nepal are a distillation of Nepalese culture and acculturation through a long and slow process of history. Even today, there are such wide differences in the beliefs and practices of the various tribes within Nepal that any attempt to generalize must be hedged with caution.

1.2.Statement of Problem

Globally, the WHO (1997) figure suggested that only 30% of people are getting health services from local health providers. A report by Moin Shah

et al., cited from Dixit (1999), has stated that government health services provide barely 10% of all consultations for people seeking health care. Dixit (1999), referring to Shrestha R. and Shrestha M., highlighted Nepal's existing health delivery system; what has been accepted even by the authorities is that the health services provided by the government reach no more than 10-15% of the population. It is also noted from the study undertaken by Chalker, who worked with BNMT, cited from Dixit (1999), that the traditional healer is the first healthcare provider. It lets us rethink why people are not accepting the health services provided by the government for such a long time. Why are those people reluctant to accept the health education message, or have they proven untouchable through several decade-long IEC interventions? These are such problems which need to be assessed today.

Agarwal (n.d.), in his book entitled *A Guide to Alternative Medicine*, writes Traditional medicine is the original medicine. Still, factors such as rapid development in science and technology, social and political reasons, organized efforts of medical and health industries, westernization etc., have led the traditional and age-old time-tested healthcare systems into a depression. People naturally started assuming that newer and more expensive care must be better and guided by the medical profession; they were brainwashed into believing that anything that was not Orthodox western medicine was either harmful or useless. It led to legislation which controls the practice of medicine by people who are doctors in most countries.

Agarwal (n.d) has remarked that, as with so many things today, the whole subject revolves around money. Orthodox medicine receives billions of dollars to set up theories, test them and report on the results. Almost no funds are available for traditional medicine, so the research is not done. It's a vicious circle. No money, no research. No research means there is naming it as such unscientific. And this led to lagging in such traditional medicine that is serving two third populations.

Usually, government and NGO reports reflect mere achievements as services provided through programs quantitatively, which is more likely as a view looking from their side. At the same time, a holistic picture of a health system is always lacking qualitative and quantitative because we can not ignore any community behaviour in assessing their health-seeking behaviour.

Therefore there is a place for a qualitative study about Rajbanshi's health-seeking behaviour that explores their behaviours, perception, and

suggestion that could facilitate by providing information about their health service utilization process, affordability, and satisfaction.

1.3. Rationale of the problem.

As we go through the community, it is easier to rectify that certain groups of people have lower living standards, low social status, and poor health status. Most of the indigenous people are not interested in education may be due to their culture, economy or low educational status or else. Being deprived of education, they naturally lag socially, economically, and in health status. HMG's/MLD National Committee for Development of Nationalities, Prospectus (2000) has noted more than 61 ethnic groups in the country. Subba (1999) feels that these ethnic people have been marginalized for the last 40 years, so they are now deprived and far from access to any facets of development. Bhattacharya (2000) has advocated the need for social justice for the deprived and marginalized indigenous people since the unification of Nepal.

Due to the limitation of time shortage and given the inadequacy of available information on this subject in a country like Nepal, the proposed study is bound to be, in large measure, descriptive and exploratory. A few tentative research questions have been formulated so that the perspective while conducting the field enquiry is consistent. Even a casual acquaintance with the situation in Nepal will convince anyone that Health seeking behaviour and users satisfactions from medication practices are more prevalent in modern medicine than in Ethnomedicine or alternative medicine. But why so?

The affected people may resort to them because they have complete faith or have no other option. It may also be that the different medical systems are not competitive and are taken recourse to under different situations. These medical systems may also have their target population. The factors of age, sex, level of education and income, religion, ethnic affiliation, and rural-urban background may also be determinants of health service use and satisfaction.

According to M.P. Shrestha (Lecture 14.8.2000), more than 76 Traditional Health Care Systems exist in Nepal. Also, Nepal Health Research Council has set due priorities for research in traditional medicine. It needs efforts to recognize traditional and modern medical practices in the Rajbanshi community. This study is expected to assess the impact of health services the government provides on a group of people.

Gartoulla (1998) has mentioned in his book *An introduction to Medical Sociology and Medical Anthropology*; despite the government's

health facilities, more than 50% of health problems never reach the health services. They are treated through a system of ethnomedicine and plural medications, which are based on home remedies. Other unconventional treatment methods include commercial sales of over-the-counter (OTC) drugs, often combined with religious healing practices and culturally based treatments, which are economically beneficial to the people. Medication differs in levels of:

- The kind of providers, consumers, and referral system.
- Socioeconomic aspects of Ethnomedicine and other alternative medications.
- The various methods of medication.
- Gartoulla (1998) has also given importance to assessing Ethnomedicine and therapies as healthcare practices due to the following reasons:
 - The progress of western medical education is a recent phenomenon in the third world.
 - The institutional infrastructure for reaching modern medical treatment for everyone is far from adequate.
 - The spread of general education itself is not yet satisfactory.

Due to all these and other causes, Ethnomedicine and other traditional healing practices have continued to be our endeavour. UNICEF (1996) in Atlas of South Asian Children and Women outlines that the formal government health system is primarily allopathic. There are as many Ayurvedic, Unani and Homeopathic medicine practitioners as allopathic medicine practitioners. These alternative medical systems are prevalent in the private sector and are popular among lower socioeconomic groups.

"Needless to say, neither Rivers nor Clements nor any of their contemporaries engaged in collecting data on the primitive medical systems had any idea that they were researching health-seeking behaviour and consumers satisfactions, but it is through such efforts that health care practice owes its origin, and came to be defined as "those belief and practices relating to disease which are the products of indigenous cultural development and is not explicitly derived from the conceptual framework of modern medicine". (Foster,et,al 1978 and Gartoulla, 1998).

As our primate ancestors evolved into humans, the disease they brought with them, and those acquired along the evolutionary ways, became social and cultural facts and pathological stages. For human beings, the disease threatens the well-being of sufferers and their fellows and the integrity of the community. Illness and death are disruptive events

that impose high economic, social and psychological costs wherever they occur. Quite apart from humanitarian reasons, it is of primary importance to the members of every group to try to maintain their Health and restore Health to those who fall ill. (Gartoulla, 1998).

Every human community has responded to these challenges by developing a medical system, i.e. the pattern of social institutions and cultural traditions that evolves from deliberate behaviour to enhance Health. Written sources tell us about the history of some medical systems. In addition to contemporary scientific medicine, we know much about the origin and development of traditional Chinese medicine, Indian Ayurveda, Muslim Unani and ancient Greek medicine and its modern descendants, and the humoral pathology of Latin America and the Philippines. Other medical systems of those people who, until recently, have lacked literature reveal little of their medical history. However, through anthropologists' studies and others such as missionaries and doctors, these alternative medicine practices have also been receiving some attention. (Gartoulla, 1998)

In recent years, the public health field has grown rapidly. Still, since this is a relatively new field, a widely shared definition of the field and agreement about the boundaries are emerging slowly among community health scientists. One definition is that public Health encompasses the study of medical phenomena as they are influenced by social and cultural features and social and cultural phenomena relating to medical practices. (Liebman, 1973) Also, public health enquiry elucidates the factors, mechanisms and processes that play a role in or influence how individuals and groups are affected by these problems, emphasizing patterns of behaviour. (Fabrega, 1972) In any case, what is of prime importance is that a greater understanding of behaviour relating to Health and diseases enables one to effectively intervene in social welfare measures. (Gartoulla, 1998)

Self-medication comprises Shaman/Dhami/Jhakri, Herbal/ root/ plant, drug retailers, grocery, kit bag, neighbour, following old medicine and prescriptions, etc. Likewise, Alternative medication consists of Ayurvedic and Homeopathic medication and traditional practices as explained in self-medications. Popular medicines are both self-medication and alternative medications. The reason why they used to go to health facilities and what was the outcome as satisfaction; is one of the essences of this study. Because "In Nepal, a modern medical system is not yet widely prevalent. In modern medicine, as it has developed over the past

three or four centuries in the west, it is assumed that qualified and authorized medical practitioners will administer medicine.

The medicine-man indeed formed a distinct category in most of the primitive civilizations, but a duly qualified doctor treating the requirement of the patient has become a characteristic of modern society. (Gartoulla, 1998). Partly because of historical reasons and partly due to various socio-cultural and economic reasons, the situation is, to a large extent, otherwise in Nepal. Despite the growth of modern medical facilities in the recent past, people do not always report to a duly qualified doctor. Still, they seek medical advice privately, not from government-run hospitals and PHCs/HPs/SHPs. The researcher has collected their perception of health services, service providers and their suggestions and expectations.

CHAPTER- II LITERATURE REVIEW

2.1 Global Situation.

Various organizations and scholars have done studies on health-seeking behaviour and self-care practices. However, all such studies do not describe and explain this issue in all its social aspects. For obvious reasons, every study has a partial focus on specific areas and topics. Nevertheless, many of them are useful and hence, have been drawn upon for their methodology and contents.

The researcher reviewed disease prevalence and health-seeking behaviour-related literature. The literature has used primary and secondary sources such as articles, journals, magazines, abstracts, leaflets and books. Researchers find some studies about disease prevalence and health-seeking Behaviour in particular districts and groups of people. However, nothing literature has been found about the Rajbanshi community on disease prevalence and health-seeking Behaviour.

Bastola (1999), cited from Gartoulla R.P.; in his thesis paper, has stated as among the occasional studies that make references to the cultural and behavioural aspects of health care practices and medications by the local people, more appear to have been done in the USA, or Europe or in Africa (Sjask, 1982). The kinds of drugs used, the geographic distribution of primary health care in Guatemala and Belgium (Saldon, 1981), and the medicalization of social life through self-medication in el. Salvador (Anne, 1981), the study of injections and quacks in Thailand (Lark, 1970), the system and practice of traditional medicine in Africa and Asia (Bonnerman, 1983), Chinese Acupuncture (ATCM, 1975), Hypnotism practices in Africa and South Asia including India (Sorbin, 1972), Socioeconomic factors affecting the psycho-therapy and Alternative medications in South Asia (Nichter, 1978), and utilization of self-care and cost patterns of referral in rural areas in India and Nepal (Parker, 1979) are some relevant and helpful references that have helped us formulate the problem for the present study.

Chaturvedi, et al. explain that health-seeking behaviours and user satisfaction with services of the people of south Asian people in the U.K.

experience greater delays than Europeans in obtaining appropriate specialist management. Still, the causes are unknown (Chaturvedi, et al., 1997). In the Health behaviour ethnology, Kilonzo, et al. describe as the human plague has been an important public health problem in Tanzania for over a century. Efforts to cure the disease through conventional methods have been applied yearly, but plague cases and death continue to occur in the area. (Kilonzo,et.al,1997). It means patients'/users' satisfaction would not be satisfactory due to problems/ diseases.

Other studies by scholars explain that the cost of treating the disease in the country has not been documented in Ghana (applies to Nepal too). Knowledge about the cost of treating malaria can affect the healthcare-seeking Behaviour of people and justify the increased expenditure for malaria(disease/problem) control. (Aseno, et. al,1997). One health education message in sexually transmitted disease (STD) control is the patient's adopting appropriate health-seeking behaviours. It includes reporting to health facilities for appropriate diagnosis and treatment. Of the total, 74.5% admitted to self-medication before reporting to the clinics for STDs (Adu, 1997).

Health-seeking strategies and Sexual Health among female sex workers in urban India indicate that women's understanding of (sexual) Health, treatment-seeking and service utilization is shown to be generally (biomedically) appropriate, but subsequent "non-complaint" therapeutic practices give cause for concern. Operational research and policy formulation on the provision of effective health services (Evans, 1997) suggested. Explanations for illness were used by Ciskeian villagers (South Africa) to account for conditions ranging from diarrhoea and tuberculosis to anxiety and hypertension (Segar, 1997). It suggests that the patient's satisfaction with the treatment is inadequate. A study in the Philippines by Boston in January 1992 shows that malarial cases were substantially under-reporting. Strain-specific immunity established the incidence (Bustos, 1997), leading users towards chronic problems while contacting healers made more critical. Doctors' treatment took a long time, making them unsatisfactory due to their causes, but blame on providers' services.

Modern medication practices (Allopathy) are scientific because of enormous research accomplished, so it has a predominant role in the country's health system. Contrary to this, Self-medication is an often chosen practice in Nepal. Gartoulla (1998) states that Self-medication consists of drug shops and various types of practitioners of traditional medicine (Ayurvedic, Chinese, Homeopathic). Also included in this category are spiritual practitioners such as shamanism, priests,

Dhami/Jhakri, and astrologers. People can also use herbal medicine (roots, grasses, plants), which they can either collect in the forests or purchase from practitioners or shops.

In their study, Haak, H. and Hardon, A.P. have shown that indigenous medical concepts are applied to western pharmaceuticals. They found that the integration of western pharmaceuticals into the local culture is achieved in various ways:

Traditional concepts of efficacy are used to describe their effects; Western pharmaceuticals are sold alongside other daily requirements in small neighbourhood shops; Pharmaceuticals are used in a culture-specific way: Pharmaceuticals receive local names and, conversely, give their names to traditional medicines. All too often, programs for rational drug use focus on healthcare providers, assuming that their education will lead to more rational drug use. Prescription-only drugs, however, are used widely in self-medication; the practices are culture-specific and cannot be ignored.

Herxheimer, A. and Stimson, G.V. have argued that people assign meaning to medicines and that these meanings differ between groups and within cultures. People's medication practices and beliefs are discussed extensively. It is concluded that most treatments for everyday illness are not obtained from a doctor. Self-treatment is a norm. (Herxheimer,et.al 1983).

Tan, M.L. raised questions about the validity of labels such as 'western' 'alternative' and 'traditional' applied to medical systems. Pluralism in diagnostic and therapeutic procedures must be recognized even within one system. A review of socio-historical factors that influence medical systems highlights important processes such as cultural reinterpretation and indigenization that characterize the 'traditional' medical system (Tan, 1989), Overgaard, L.B. and Holme, H.E. (1985) have analyzed medicine behaviour seen from user's point of view.

Conrad, P. (1985) has also presented a paper with an alternative patient-centred approach to managing medications. The study focuses on the meaning of medication in people's everyday lives and examines why people take or do not take their medication.

Blum, R. and Kretman, K.(1983) described the factors that affect the habits of medicine users. They show how medication varies with the symptoms of the patients, their sex and also their lack of knowledge of the current use of medicines. Foster, G.M. (1984) suggests that modern medicine in recent years has become the first choice for most traditional people most of the time. Concerning the use of traditional curers in

primary health care, it is pointed out that: they are not replacing themselves; They may have become 'neotraditional curers' making extensive use of modern drugs; and

Spiritualist curing is replacing much traditional medicine.

Geest, S. Van der et al. (1990) believe that the public health field does not suggest that programmes for 'rational drug use' can be easily implemented. The commercial context of medicines and the new meanings they acquire in local settings give rise to very complex situations.

The study by Ashraf, A. et al. (1983) on disease and health care in rural Bangladesh sought to find out how the fields of traditional, folk and allopathic medicine were related to each other and what processes could be discerned in these interrelationships. The outcome was that traditional medicine has almost disappeared in this area.

Batia, J.C. et al. (1957) studied 93 traditional healers in three states of India, showing that they increasingly use modern/ allopathic medicines in their practices.

Self-medication: WSMI (2001) says, "Self-medication is the use of specifically designed, labelled and authorized medicines available legally without prescription for the treatment or prevention of common illnesses, which the people can recognize. Traditional medicine frequently is not included in the national health system. If traditional medicines are legally available without a doctor's prescription, they are included in self-medication. As perceived by different scholars in the past, self-medication is as follows.

The active medicine user falls under self-medication. (Overgaard, 1985)

Parker defines self-care as the culture, medicine and psychology of people. (Parker, 1979)

The illegal distribution and use of western medicine is self-care. (Sjaak, 1982)

Lay diagnosis and practice of any medications and popular healing practices is self-medication. (Chaturvedi, 1997)

Any object used for illness is self-medication. (Herxheimer, 1983)

Self-medication is indigenized pharmaceuticals in a developing country. (Haak et al., 1988)

Self-medication is when medications are applied by users either contacting providers or themselves, except for the present prescription of a duly qualified medical practitioner (Gartoulla, Ferguson, Geest, et al.)

Traditional and transitional medicine system is the component of self-medication. (Tan, 1989)

Popular medicines are used as polypharmacy, ethnomedicines, herbal and amulet objects, and animal objects selected by users or given by sellers/ providers.

Ethnomedicines is that the herbs and herbals used by local people collected from local yards and have shamanistic usage.

Traditional medicine includes ethnomedicines, shamanism, priesthood and worshipping together.

Commercial pharmaceuticals medicine used by self, either buying directly or provided by untrained retailers, is also called self-medication. (Ferguson, 1981, Ashraf et al.)

Individual use of medicine is self-medication. (Blum, 1983)

The overwhelming belief and practice of herbal plants as medicines and the use of allopathic medication by the kit box (bag) is self-medication. (Bennerman, 1983)

WSMI (2001) has pointed out that Alternative medicine is a medicine which is outside the regular allopathic medicine. Similarly, Alternative medication as perceived in the past:

Alternative medicines are defined by health-seeking Behaviour. The users use those medicines a second time than the first time.

Self-medications, popular medications, ethnomedicines or traditional and or alternative medicines have been used in different situations.

Mabuhang (2000) wrote an article entitled Policy approaches to indigenous people's health issues. He mentioned much about Indigenous people, especially the relative situation concerning the different conferences, declarations and global data. It is now almost three decades before for the first time when the population was considered an integral part of the socioeconomic problem, the Bucharest Conference, 1974 has said:

It is recommended that health and nutrition programs designed to reduce morbidity and mortality be integrated within a comprehensive development strategy and supplemented by a wide range of mutually supporting social policy measures; special attention should be given to the formulation of policies to widen their coverage to reach, in particular, rural, remote and underprivileged groups.

Mexico Conference on Population and Development (1984), cited from Mabuhang(2000), also gave guidelines for the government:

As a matter of urgency, the government should make universally available information, education and the means to assist couples and individuals in achieving their desired number of children. Particular attention should be given to those segments of the population most vulnerable and difficult to reach (U.N., 1995).

The Bucharest conference highlighted the increased attention that should be paid to the relative importance of various socioeconomic and environmental factors in determining mortality differentials by region or socioeconomic and ethnic groups. Later Mexico Conference (1984) recommended that the "Government should ensure the rights of indigenous and other groups."

Under its plan of action, after twenty years of efforts made in population and development, the International conference on population and development 1994, cited from Mabuhang (2000), has said:

Indigenous people have a distinct and important perspective on population and development relationships, frequently quite different from those of the populations with which they interrelate within national boundaries. (U.N. 1994)

In May 1994, the forty-seventh World Health Assembly adopted resolution WHA 47.27, in which it called upon the Director General, inter-alia, to increase cooperation between the World Health Organization (WHO) and other United Nations Organizations to help meet the health needs of indigenous people, provide member states with technical support,

to assist governments and I.P.s in addressing health needs in a culturally effective manner, to consider the contribution WHO might make to promoting respect for, and maintenance of, indigenous knowledge and to ensure that relevant research projects undertaken by WHO and other United Nations Organizations were conducted in consultation with, and for the benefit of indigenous people and communities (Daes, 1996).

The world women's conference -1995 held in Beijing, uncovered that the major barrier for women to the achievement of the highest attainable standard of Health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups (Mabuhang, 2000).

The World Summit for Social Development was held in Copenhagen on March 6 to 12, 1995. The largest gathering yet of world leaders - 117 Head of State or Governments- came together to talk about global responsibilities for eradicating poverty and unemployment and fostering social integration. In the final declaration among others, among others, a direct reference to I.P.s' Health is found commitment 6(g) (cited from Mabuhang(2000):

Recognize and support the right of indigenous people to education in a manner that is responsive to their specific needs, aspirations and cultures and ensures their full access to health care.

International Consultation on Health of Indigenous Peoples, held in Geneva from 23-26 November 1999, organized by the World Health Organization. In part 1, the declaration focuses on the rights and interests of the world's I.P.s. Declaration affirmed "the right to the highest attainable physical, mental, social, cultural and spiritual health and survival, commensurate with Indigenous Peoples' definition of health and well being." It was called on the WHO to make a substantial contribution in the context of the International Decade of Indigenous People (1994 to 2004) (cited from Mabuhang(2000).

The second part of the Geneva declaration says: "I.P.'s concept of Health and survival is both a collective and individual intergenerational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are spiritual, intellectual, Physical and emotional. The four fundamental dimensions, Health and survival, manifest themselves on multiple levels where past, present, and future co-exist simultaneously. For indigenous peoples, Health and survival is a dynamic equilibrium, encompassing interaction with life processes and the natural law that governs the planet, all life forms, and spiritual understanding.

Expressions of culture relevant to the Health and survival of indigenous peoples include, but is not limited to, individual and collective relationships, family and kinship systems, social institutions, traditional justice, music, dances, ceremonies, rituals, performance and practices, games, sports, language, narratives, mythology, stories, names, land, sea and air and their resources, designs, writings, visual compositions, permanently documented aspects and form of indigenous culture including scientific and ethnographic research reports, papers and books, photographs, digital images, films and sound recordings, burial and sacred sites, human genetic material, ancestral remains, and artefacts (cited from Mabuhang(2000)).

Kleinman (1984) has noted that the individual, family and community assume a vital responsibility for its members' health promotion and curative care. In many societies, as much as 70-90% of all curative activities may occur within this network. Several studies in western and non-western societies support this statement (cited by Mabuhang (2000)). The global situation in diseases' rank order changes is also of great concern. CHD, for instance, considered rare for two decades, has now become common in urban Nepal. World Bank has assessed the global situation in this changing pattern issue of disease prevalence. (Annex - III)

WHO report 1999 shows a clear comparative picture of I.P.s Health Indicators in Comparison to Non-IPs by Different Regions of the World.

In the Arctic and Russia, Indigenous people (IP) have a higher rate of disease prevalence, mortality rate, and infant mortality rate than the general population (G.P.). In contrast, the general population has a higher life expectancy than the I.P. Pneumonia prevalence is 60 times higher in Alaskan natives than in the U.S. population. In Australia, aboriginal communities have a higher rate of disease (1979-91), and infection and parasite rates are 22 times higher.

In Canada, the smoking rate is 43%, and cancer prevalence is higher among native Indians and Inuit. Aboriginals have a life expectancy of 66 years, whereas Canadians have a life expectancy of 71 years. In India, approximately 12% of I.P. children die before school age, compared to 4.8% of the general population. In the last four years, 3,821 Korku state I.P.s children died from starvation/malnutrition (WHO,1999).

Definition of Indigenous Peoples: World Bank (1991) proposed the following definition of I.P.s, cited from Mabuhang (2000):

"A close attachment to ancestral territories and the natural in these areas; self-identification and identification by others as a member of distinct cultural groups; an indigenous language, often different from the

national language; the presence of customary social and political institutions; and primarily subsistence-oriented production."

ILO's convention 169(ILO,1996) says, cited from Mabuhang (2000):

"Peoples in independent countries are regarded as indigenous people on account of the descent of the population who inhabited the country, or geographical region to which the country belonged at the time of conquest or colonization or the establishment of present state boundaries".

Health Seeking Behaviour: WHO defines Health as a state of complete physical, mental, social, and spiritual well-being, not merely the absence of disease and infirmity. Oxford Learner's dictionary defines Seeking as having, doing, looking, and Behaviour means habit, performance, and culturally and socially motivated activities. Health Seeking Behaviour is a habit of a people or a community resulting from the interaction and balance between health needs, health resources, and socioeconomic, cultural, political, and national/ international contextual factors. Health Seeking Behaviour in this study as assessing the habits of Rajbanshi in using modern, self and alternative medications. It also explores the causes, cost and satisfaction of treatment and practice.

Modern Medicine: Allopathic medicine prescribed by a duly qualified medical practitioner. The second contact as an alternative is usually found after self-medication.

Alternative medicine: indicating Ayurvedic and Homeopathic medication only.

Self-medication: Kafle and Gartaula (1993) and Gartaula (1998) have categorized self-medication as Shamanism, Priest, Dharmi-Jhakri, herbal, drug retailers, grocery, kit-bag, drug peddler, neighbour, following old medicine prescriptions and accept the present prescription by a qualified medical practitioner. Worship god and going to the traditional healers are accepted practices while getting sickness is common. Anybody readily does this practice herself or himself even before starting any treatment. So, Self-medication comprises Herbal, Drug retailers, Grocery, Kitbags, Drug peddlers, neighbours, and following old medicine and prescription and traditional healers in the study.

2.2 Studies related to health-seeking behaviour in Nepal.

According to Dixit (1999), the reality is that the expansion of health has not occurred, neither in the government nor the private sector, to the extent that it is even required to increase the population. Onta (2000) noted that the government's commitment towards assuring people's health could be largely assessed through analysis of the national public policies of the

country. To ensure that every citizen has an equal opportunity of access to health services and no one is left out and marginalized, the spirit of social justice and equity should guide the health system.

In Nepalese belief, illness is often associated with spirit possession. Therefore, the appropriate healer is the faith healer. Blustain (1976) suggests that if health care in Nepal is to be improved, one must have the villager's faith in their healing techniques, be they herbal or ritual, is not going to be shaken by the occasional visits of medical teams or even by the building of hospitals. Chalker et al. (n.d.) also suggest that in the countries like Nepal, Government should be concerned with traditional health care and professional practitioners and are drawn into partnership with the government health delivery system to provide basic health care to rural people.

Poudel et al. (1998) undertook a study conducted in the Kavre district. It was found that 100% of the sample respondents have never been to a traditional healer for any treatment during their lifetime. Among them, 75% used a healer during the last six months for their last sickness. Whereas 91.6% of respondents first reported to a healer even though the healing practice of a healer did not satisfy the majority (61.66%). Mostly the healer used multiple healing practices like blowing with wisdom (95%), worship (37.5%), and Egg sacrifice (15.83%). At the same time, animal sacrifice was rarely practised (10.83%), and no other harmful healing practices were found. The majority of respondents (65.84%) provided in their home like alcohol, meal, cigarette, and cereals as a treatment charge. The respondents used healers because of their strong cultural beliefs and long-term relationships.

They have found in their study conducted in the Kavre district that there is a significant relationship between the educational level of respondents and utilization of the healer, economic status of the family and the utilization of the healer. At the same time, there is no relationship between the utilization of healers with other variables like distance of health institutions, types of family and age of the decision makers on health-seeking behaviour in the family.

Various studies have been done on health-seeking practices and health status, covering modern and traditional medical care systems. However, a few major studies that have been kept in view while conducting the present one are described below based on their focus and coverage.

Justice, Judithene did a study in 1981 on health planning in Nepal. She discussed the system and structure of health administration in the past

and the contemporary period. K. K. Kafle has examined the current situation regarding training for health workers at various levels in the presentation of drugs. Important criteria for the rational use of drugs are:

National drug policies are based on the essential drugs concept, accurate information to health care professionals and an effective national system for excluding needlessly expensive and harmful drugs. Problems and constraints include a lack of adequate drug information, inadequate drug supply and non-utilization of services. Recommendations are made regarding improving the situation (Kafle, 1987).

The performance of health workers in Primary health care in Nepal (IOM, 1985) the five-year (1974-79) experience of a community health program in Lalitpur (Kathmandu valley) to train local indigenous midwives, (Mugedal, 1979) an account of basic health care work done from 1979-82 in Dolakha district of Nepal as a part of IHDP (Aehard, 1983) may be mentioned in this connection. Poverty, unhealthy living conditions and malnutrition, particularly among women and children, as contributors to poor health, and the evolution of the Nepalese primary health care (PHC) system has been described by Mathema (1987). The purpose of the study in Sindhupalchok of Nepal was to document the nature of available indigenous and modern nutrition and public health services in rural communities (Shrestha, 1986).

Over the last decade, many developing nations have embraced primary health care (PHC) within their national health plans. Linda stone, in her study, has emphasized community participation on the one hand and the actual approach taken on the other (Stpme, 1986). In the last two decades, the great expansion of primary health care in rural areas of developing countries has not been matched by significant improvements in health standards, and Nepal is no exception (Oswald, 1983).

A study on alternative medications indicates various forms of health-seeking behaviours of consumers in the communities of Nepal (Gartoulla, 1998). Ethnomedicine is the primary concern of medications in Nepal (Gartoulla, 1998). Essential drug utilization on TU. Teaching hospital indicates that most of the antibacterial drugs were from the essential list (Kafle et al., 1988), reducing the cost for people. Laboratory use for urine examination brought another report to support patients satisfactions in Nepal (Tuladhar et al., 1987). The unpublished report on child survival pharmaceuticals in Nepal indirectly explains patients' satisfaction and behaviours (MSH, DMP, New Era, DDA, BNMT, IOM, 1988).

Medical services stand for clinical contraceptives, and VSC in Nepal (Bhatta, 1990) explains patients satisfaction; Drug funding schemes in

Nepal show that 13% of the population attended a health post or hospital each year (Chaler, 1997) which means health-seeking institutions in the hospital/ HP is poor. Quality control of pharmaceuticals and medicines in Nepal has about 350 samples to analyze (Karkee,1994), indicating poor services. Self-medication and its impact on essential health drug schemes in Nepal indicate that more than 50% of people contact /practice self-medication (Gartoulla, 1992; Kafle et al., 1993).

Drug prescribing in-out patients in Teaching hospitals explains that vitamins and minerals were prescribed in more than 20% of cases (Kafle et al., 1991) means patients have a financial burden, and the long-term consequence is almost dissatisfaction. Almost any drug may give rise to problems if used improperly, but certain drugs are especially problematic (Joshi et al., 1991). Physician's practice pattern; in the private sector indicates that generic prescribing in the private sector is almost non-existent (Ghimire, 1992) in Nepal. The average number of drugs prescribed per patient was 8.1 (Joshi et al., 1992) means the burden financially affects patients' satisfaction negatively in Nepal.

Thus, many literature and studies indicate the importance of explorations on health-seeking behaviour and consumer satisfaction from service providers. They are searching for less expensive, adjustable, faith and affordable options. This study assesses consumers and their satisfaction using what types of medication.

CHAPTER-III METHODOLOGY

Framework displaying Cause and Effects

3.1. Based on Education:

Rajbanshi both literate and illiterate were selected and assessed whether or not they were getting satisfaction from Traditional medication or Modern medication. The researcher has assessed the reason for choosing health services, treatment costs and trends.

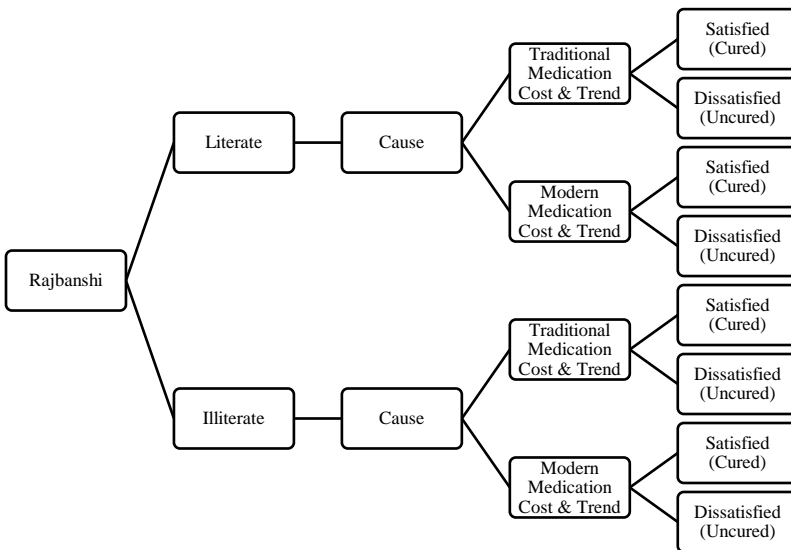


Figure 1 indicates the possible factors associated with medication patterns as well as local healing practices. The possible indicators for both literate and illiterate are: cause, cost and trend, cured/uncured satisfactions/dissatisfactions from traditional and modern medications. This provides the entire process of why they choose the specific system or practices.

3.2. Based on Economic status

Assessing sickness, affordability, and satisfaction based on economic status is essential. So, the researcher has done a study on this issue. It assessed the treatment cost, and what they do to people who are unable to afford it.

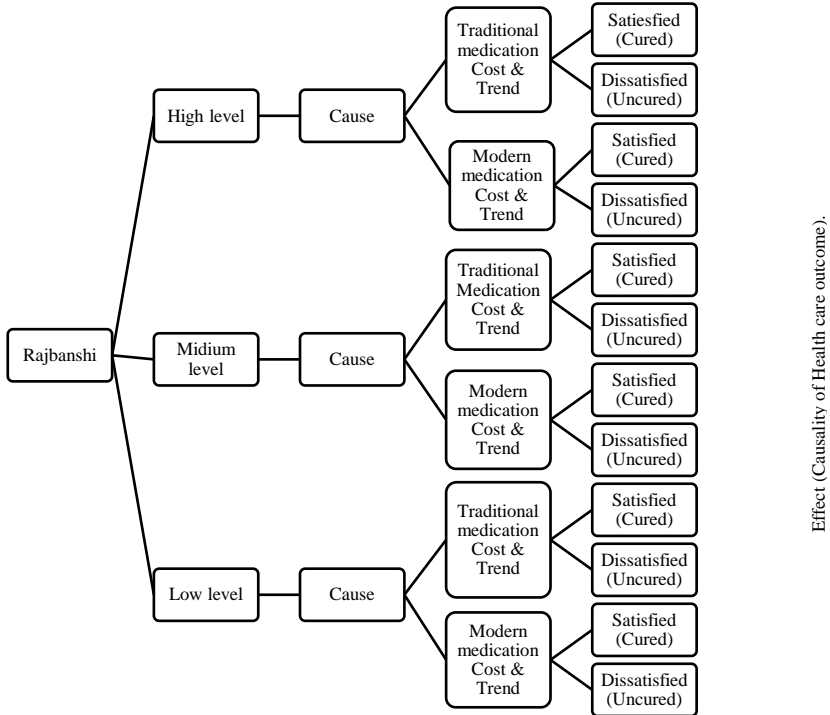


Figure 1 Cause and Effect by Economic condition

Note Economic status: Low= 0-1Bigahs, Medium= 1.1-4 Bigahs, and High level= 4.1 Bigahs and above. Animal husbandry, types of houses, and family size are other elements included in economic status.

Figure 2 indicates one of the major factors determining health, i.e., an economic base. The indicator for determining health on it- the economic level on which one decides to get treatment locally which might be a traditional or modern one.

3.3. Distance of Health Institution

It is a researcher's concern what is the role of distance in choosing a health facility. So, it was also assessed as a determinant of choosing a health facility.

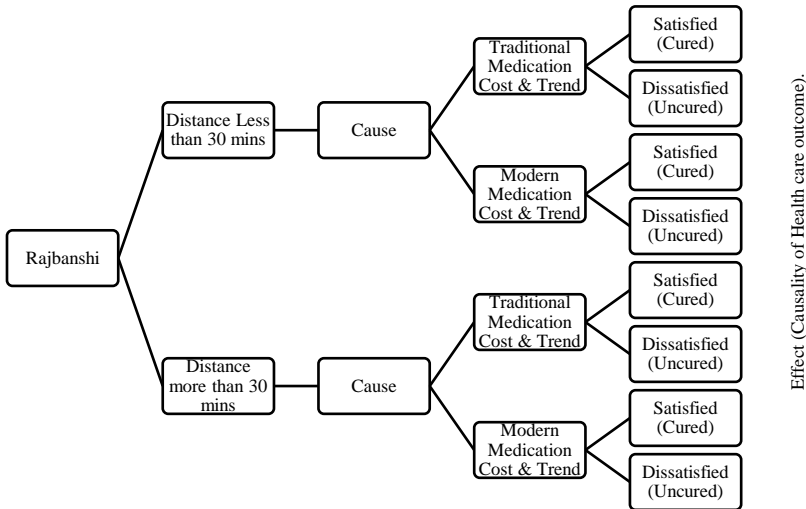


Figure 2 Cause and Effect by Medications

Note Both modern health institutions and traditional all sorts of institutions/persons.

Figure 3 depicts how people choose between home treatment and government health institutions based on distance. It is divided into 30 and >30 minutes of walking/bus transportation. And because of the distance for medication, they choose (traditional or modern), the level of satisfaction from treatment has been seen, as well as cured and uncured. As a result, distance is an important aspect of home treatment.

3.2 Variables.

For this study, the dependent variable is Health Seeking Behaviour and self-medication and alternative and popular medications at the community level. The independents are local resources, socio-economic-cultural factors and distance.

Table 1 List of Variables

Variables	Dependent	Health Seeking Behaviour (Modern medicines and or Self-medication and or Alternative medication)
	Independent	<ol style="list-style-type: none"> 1. Socio-cultural factor 2. Economic factor 3. Educational factor 4. Health practices and facility 5. Distance of Health facilities 6. Local resources

The independent variables determined the dependent variables for the indicators mentioned above. People adopted Self-medication due to their long-term relationship (cultural relationship) with local providers, low cost, easy to meet, healers come to the user's house, walking distance, socially accepted and culturally sanctioned.

3.3. Operational Definitions of the Variables.

Health Seeking Behaviour: It is the treatment-seeking behaviour of the Rajbanshi community for the latest illness, as reported by them. It will be categorized as (a) Modern medication as Hospital, HP/SHP and private clinic (b) Alternative medication such as Ayurvedic, Homeopathic and Unani systems of medication; and (c) Self-medication such as Dhami/Jhakri (Shaman healers), drug retailers, grocery keepers, drug peddlers, household medicine and other than modern and alternative medicine.

Dhami/Jhakri = Shaman who exorcise evil spirits from the bodies of sick people, and they use drums and sticks in their nightlong healing rituals.

Education:

Uneducated = Illiterate and literate below SLC.

Educated categorized as SLC, IA, BA and above.

Economic status: Possession of land as reported by the respondents, categorized as 0-2 Bigahas=Low, 2.1- 4 Bigahs = Medium, 4.1 Bigaha above=High Level.

3.4 Conceptual Framework (For qualitative analysis).

The determining factor of health-seeking behaviours has been conceptualized as above - Health Seeking behaviour is closely related to traditional medicine, Shamanism, religious act, self-medication etc.

These are also influenced by tradition, family patterns, cultural appropriateness, faith, low cost, interpersonal relationship, redness, advice from siblings/relatives, availability, personal choice etc. Availability and

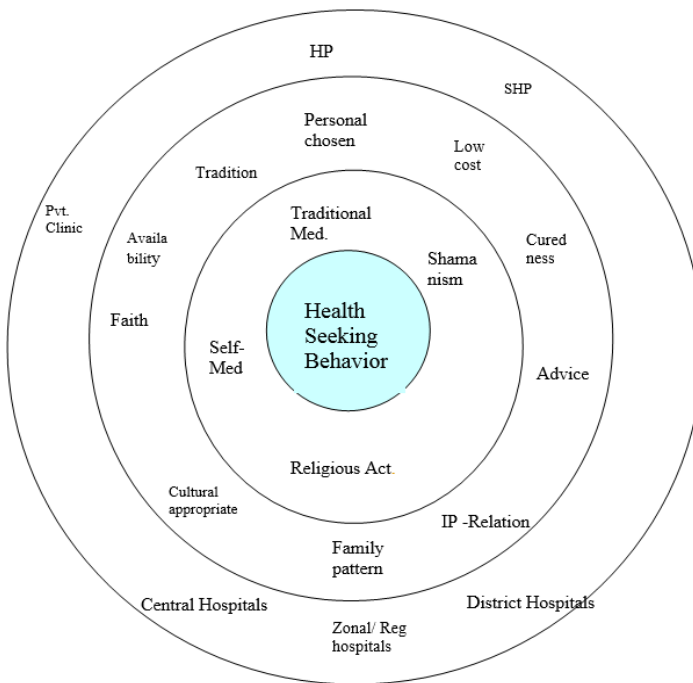


Figure 3 Conceptual Framework

access to modern medication facilities such as SHP/HP, Hospitals, and private clinics determine the health-seeking behaviour of a community.

3.5 Research Questions.

1. What are the practices as well as a cause of seeking traditional and modern health care?

2. Whether they are satisfied or not with their medications and behaviours?
3. What is the cost of curing an illness or disease or the cost borne for their medications?

3.6 Limitations:

1. The availability of sufficient medical facilities in Biratnagar, near these VDCs, has played a biased role in the study.
2. Only the past three months' history has been taken while filling out the questionnaire. So, it may produce variation in morbidity data and be unable to represent the morbidity of a whole year.
3. Since only two VDCs - Katahari and Baijanathpur, which are situated nearby Biratnagar; Were subjected as a sample, they may not represent the picture of the whole Rajbanshi.
4. It may represent the cross-sectional picture of only Katahari and Baijanathpur VDCs of the Morang district.

3.7 Objectives.

General Objectives:

To assess the health-seeking behaviours in the Rajbanshi community.

Specific Objectives:

1. To find out the practices of using traditional and modern medicine in the community.
2. To assess the satisfaction and dissatisfaction with traditional medicine and modern medicine or health services available in the community.
3. To assess the expenses for their health expenditure.
4. To know various methods of self-care and types of therapy used by consumers.

3.8. Study Design.

The study is an exploratory, descriptive and cross-sectional study based on a household survey quantitative analysis and Focus Group Discussion (FGD) and observation for qualitative information. This study has assessed the healing and caring practices under the health-seeking behaviour of the Rajbanshi community.

3.8.1 Study Area.

This study was conducted in two different Villages, Katahari and Baijanathpur, of Morang district, selecting purposively based on thick settlement. Morang is a district having 49 Sub-Health Posts, 11 Health Posts, 7 PHC, One district-level Rangeli Hospital and a regional-level Koshi zonal Hospital. These two VDCs are located nearby the Koshi zonal Hospital Biratnagar.

3.8.2 Study Population.

Both males and females were taken as the study population. Those with ill/ sick/ disease or medication within three months were the study population. The head of the household was the respondent for quantitative, and most users were for FGD for its quantitative information.

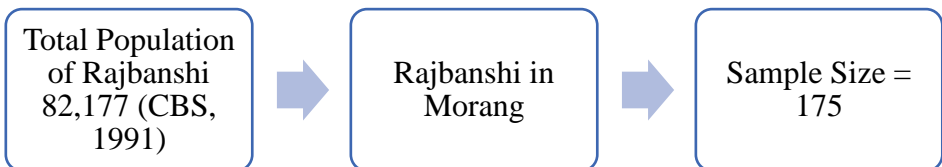
3.8.3 Sample Size.

For the reference calculation, a study was conducted in the Kavre district, where more than 90% of people use traditional medicine. So, we have $p=90$ and $q=10$.

We have the formula to determine the required Sample size $(n) = 4pq / L^2$

If, $L = 5\%$ of p . $= 90 \times 5/100 = 4.5$

$n = 4pq / L^2 = 4 \times 90 \times 10 / 4.5^2 = 3600 / 20.25 = 175$.



175 households of two VDCs were selected from the VDCs rosters using a random number table for convenience and to cover the expected households.

3.8.4 Process:

The researcher visited the households according to a random number table. They were asked relevant questions about the history of illness/disease within three months from the interview date. The researcher took the demography for those who were ill/sick persons of the above criteria and case consulted for detailed information.

1. Roster analysis of VDC, DDC.
2. Secondary Sources.
3. Instruments.
4. Consent-Verbal
5. Interview.
6. **Focus Group Discussion.** The participants for FGD were requested to have one and half an hour's sessions because of their self-medication during household visits. Personal contacts with 8 people with one FGD and a total of ten FGD with 80 people. They were treated by self-medication within three months of the study period,

3.8.5 Instrumentation.

Development of Tools.

The structured and in-depth questionnaire was prepared to interview people with a disease. So, the interview would explore their health-seeking behaviour.

1. Individual Interview. (With schedule, i.e. questionnaire to be applied for provider, user or respondents)
2. Observation of medicines, if any.
3. Focus Group Discussion guidelines.

3.8.6 Data collection procedure.

At first, there was a visit to DDC, DPHO and VDC to have a meeting to discuss its relevance and the importance of the study. It was expected to have permission from concerned authorities and attempt to ensure their necessary help.

3.8.7 Ethical Consideration.

The purpose of this study was to give first preference to the respondent at the time of the interview. The researcher collected data with verbal consent, not forcefully. There was taken care of full confidentiality.

3.8.8 Data generation, data storage and data safety procedure.

It ensured the completeness and accuracy of the filled questionnaire.

1. All information belonging to respondents is kept confidential.
2. The researcher uses the result only for the purpose stated in the study.
3. No information will be published, which will break the anonymity of the respondents.

3.8.9 Data Processing.

First, all data collected were coded as required then all data collected was entered into a computer for data processing. After this, analysis was carried out with the software EPI-Info-6 in the computer to get the result or outcome. The information from the Focus group discussion was transcribed and generalized manually.

3.8.10 Analysis.

The study uses quantitative and descriptive methods. The researcher used the qualitative methods manually while analyzing the data. The quantitative analysis focussed on frequency, mean and percentile by using above-mentioned computer or EPI-Info-6 software to see the related significance test. For this, the chi-square test was used on a computer.

3.8.11 Interpretation.

All the data was tabulated with various types of singular or cross-tabulation. Charts and tables are used to analyze the data and summarize the data.

3.8.12 Discussion.

After accompanying the analysis and interpretation of data, the discussion was held based on objectives and indicators. Regular consultations with a guide were made/done.

3.8.13 Write-up.

The researcher prepared the discovery draft, presented it to the supervisor, and attempted the revision as per the feedback. Then investigator submitted the report again to the supervisor and other experts for necessary guidance and revision. It is again revised and corrected for the second time and then submitted to the supervisor. Now this report will be finalized and documented as a thesis report. The final report has been documented as a thesis report and has been submitted to the research committee.

3.9. Relevancy and Applicability

This study has measured the use of modern, self and alternative medicine as well as the status of literacy, economic condition, and distance of health facility. It has assessed the level of satisfaction with their traditional healers and health facilities in the community. As stated in the introduction, statement of the problem, conceptual framework and

rationale of the study, it is now almost clear that the identification, assessment, and description of health status and health practices of an Indigenous people (i.e. Rajbanshi) would be as substantial as well as a potential outcome for the community self and other relevant authorities. District authorities, concerning government authorities or NGO/INGO, could benefit from the study's result.

In the context of the implementation of decentralization, a bottom-up planning process, the behavioural picture of a particular ethnic group could provide some pictures for the planning process. Therefore this study is a dedication to Rajbanshi ethnic group.

So, this study has the potential to supplement the assessment of the country's overall health system.

3.10 Validity and Reliability of the Tools.

Validity and Reliability were maintained by pretest and necessary modification.

1. Investigator made regular consultations with supervisors/guides/subject experts.
2. Other concerned persons were requested to read the questionnaire and give feedback.
3. The researcher self-did fieldwork.
4. The investigator gathered the data promptly after collecting it from the field.
5. Ensuring the application of the Scientific tools.
6. Feedback from the workshop will be honoured.
7. Respondents were mostly heads of households with the age group of 20-65 yrs.
8. Eight persons in one Focus group discussion were collected according to the WHO-described Focus Group Discussion manual.

CHAPTER IV FINDINGS

4.1 Economic Condition

4.1.1 Occupation

Most of the people were occupied in the agriculture sector. And rest are involved in working as labour, business, service and dependent.

Table 2 Occupation

Occupation	Number	Percentage
Agriculture	91	52.0
Business	11	6.2
Service	14	8.0
Labour	42	24.0
Dependent	17	9.7
Total	175	100.0

Table 2 presents people how involved in different occupations. The figure shows that out of 175 respondents, 52.0% of people (91) were engaged in agriculture, followed by 24.0% (42) in labour, 9.7% (17) dependent, 8.0% (14) service and 6.2% (11) business.

4.1.2 Land

The information on the respondents' land had taken to know their economic status.

Table 3 Economic condition

Economic Status	Number	Percentage.
0-2 Bigahas (Poor)	107	61.1
2.1-4 Bigahas (Medium)	22	12.5
4.1- above (Rich)	46	26.2
Total	175	100.0

Table 3 presents the economic status of people in terms of having land. People having more than 4.1 bighas were found at 26.2% (46), people having land between 2.1 to 4 bighas at 12.5% (22) and people having no land to 2 bighas were 61.1% (107) in the Rajbanshi community.

4.2 Economic Condition and Sickness.

4.2.1 Sickness by Economic Condition

Here the land proportion and sickness have been shown to know the sickness status associated with land ownership.

Table 4 Economic condition and Sickness

Economic Status (Land)	Sickness	Proportion %
0-2 Bigahas (Poor), (N=107)	107	100
2.1-4 Bigahas (Medium), (N=22)	22	100
4.1- above (Rich), (N=46)	46	100

Table 4 indicates that out of the total 175 respondents, 100% (107) of poor people were getting sick; likewise, medium 100% (24) and rich 100% (46) were reported sick.

Economic condition and medication.

There is a close relationship between economic status and health-seeking behaviour.

Table 5 Economic condition and Medication

Medication	Poor (n=107)	Medium (n=22)	Rich (n=46)	P-Value
Modern	104 (97.2)	20 (90.9)	44 (95.6)	0.387
Self	68 (63.6)	14 (63.6)	18 (39.1)	0.016
Alternative	19 (17.7)	7 (31.8)	40 (87.0)	0.000

Table 5 presents that 97.2% of poor, 90.9% of medium and 95.6% of rich people were adopting modern medication, respectively. Poor 63.6%, medium 63.6%, and rich 39.1% people were adopting Self-medication,

respectively. Similarly, Poor 17.7%, medium 31.8%, and rich 87.0% were adopting Alternative medication, respectively. There was no difference in the use of modern medication among different economic levels that is statistically insignificant ($P= 0.3871$). The study found that the poor adopted a highly effective practice of self-medication, i.e., statistically significant ($P=0.0160$). Likewise, the rich are largely adopting a statistically highly significant alternative medication ($P= 0.0000$).

4.3 Education and Sickness

The majority of people were uneducated, as shown in the following table. Out of the 175 respondents, 35.4% (62) were illiterate, followed by literary only 38.8% (68), both combined as uneducated (74.0)%, SLC 20.5% (36), intermediate 3.4% (6), and BA - over 1.1% (2) altogether 26.0%.

Education.

Table 6 Educational status

Educational Status	Number	Percentage
Illiterate	62	35.4
Literate only	68	38.8
SLC	37	20.5
Intermediate	6	3.4
BA and above	2	1.1
Total	175	100.0

Table 6 presents the educational status of the Rajbanshi in Katahari and Baijanathpur VDCs. In this study, Illiterate and literate only were taken in the category as Uneducated, and SLC to above are being taken as Educated. A 74% uneducated population is determined to have self-medication and or follow traditional healing practices.

Table 7 Education and Sickness

Education	Sickness (n)	Percentage
Educated	45	26.0
Uneducated	130	74.0
Total	175	100.0

Table 7 presents the status of sickness based on the educational level in the community. It shows that out of 175 respondents; who were uneducated, 74.0% (130) and educated 26.0% (45) were found to be sick.

Education and Medication.

Table 8 Education and Medication

Medication	Uneducated (n=130)	Educated (n=45)	P- Value
Modern	126 (96.9)	42 (93.3)	0.375
Self	85 (65.4)	14 (31.1)	0.000
Alternative	27 (20.8)	13 (28.8)	0.263

Table 8 shows no difference in the use of modern medication between the educated and uneducated, which is statistically insignificant ($P=0.3753$). But the use of self-medication by the uneducated was significantly higher than that of the educated, which is statistically highly significant ($P= 0.0000063$). And no difference in the use of alternative medication between educated and uneducated is statistically insignificant ($P= 0.2635$).

4.4 Distance of Modern Health Facilities and trend

The study examined the distance between modern health institutions and the trend of using medication:

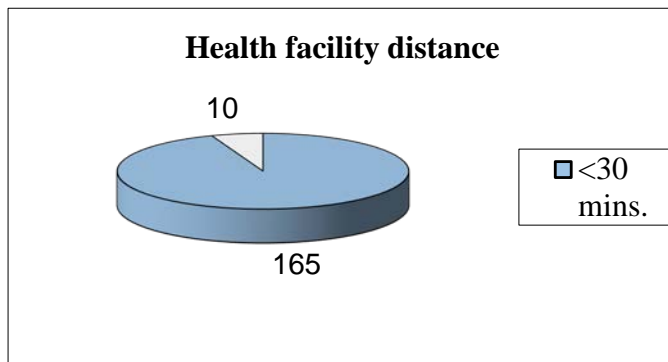


Figure 4 Distance of Health facilities

Figure 4 demonstrates the number of people far from modern health facilities. Out of 175 respondents, 94.2% (165) lived within 30 minutes of walking/ transportation distance.

4.5 Reported Illness.

The investigator noted diseases and ailments by Prescription, observation, and history taking in the survey. Respondents reported mostly symptomatic ailments such as headaches/body aches/ weakness in the community. And then, ARI, fever, eye ENT/oral problems, diarrhoea/dysentery, Gastritis, Skin disease, TB, and R.Arthritis, were reported, respectively. The disease pattern may not resemble national status. It may be due to the coverage of illness history of only the past three months.

Table 9 Reported Illness

S.No.	Diseases	Frequency	Prop. %
1	Headache, body ache, weakness	89	50.8
2	Acute Respiratory Infection (ARI)	77	44.0
3	Fever	54	30.8
4	Eye/ENT/Oral Problems	33	18.8
5	Diarrhoea/Dysentery	24	13.7
6	Gastritis(APD)	24	13.7
7	Skin diseases	13	7.4
8	Tuberculosis	10	5.7
9	R. Arthritis	9	5.1
10	Asthma (COPD)	7	4.0
11	Dogbite	5	2.4
12	Typhoid	4	2.2
13	Paralysis	4	2.2
14	Accident/Fracture	3	1.7
15	Diabetes	3	1.7
16	Jaundice	2	1.1
17	Gynae/Obs.	2	1.1
18	Kala-azar	1	0.5

(Note: Response by duplication; one person had more than one problem/ illness. Thus, of the total, 175 respondents presented 364 responses on illness. The average illness reported was 2.0.)

They reported that the illness's nature changes as the weather changes. Diseases such as ARI, TB, Salazar, and Asthma were mentioned clearly in the prescription by healthcare providers when the investigator examined the old prescription. The researcher himself observed some cases. Headache/body ache/ weakness was reported by 50.8%, ARI by 44.0%, Fever by 30.8%, Eye/ENT/Oral by 18.8%, Diarrhoea by 13.7%, Gastritis by 13.7%, skin diseases by 7.4% respectively.

4.5.1 Morbidity by Sex.

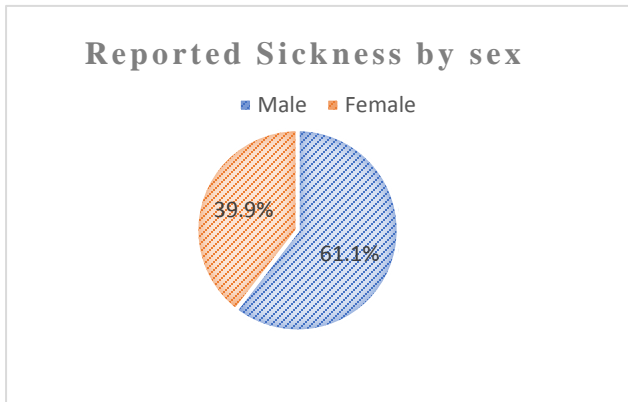


Figure 5 Latest sickness by Sex

Figure 5 illustrates that males were reported sick by 61.1% and females by 39.9%. It might be due to the gender bias in the facility and the opportunity to report illness problems in the health institutions. Rajbanshi females are powerful at household decisions, but outdoor facilities are minimum by local tradition.

4.5.2 Use of PHC-Services.

Table 10 Use of PHC-Services

PHC Services	Service takers (n=175)	Proportion Percentage
EPI Camp	139	79.4
FCHV	88	50.2
VHW	50	28.5
MCHW	19	10.8
PHC-ORC	16	9.1
TBA	10	5.7

Table 10 demonstrates the use of PHC services by any member of the Rajbanshi households in the last 3 months recall period. Most people were found using EPI-camp (79.4%) for immunizing their children. Half of the people have taken service by the FCHV(50.2). But TBA, PHC-ORC and MCHW were of relatively low access. However, it was encouraging to note that most people were aware of immunization.

4.5.3 Use of Health Care System.

Modern medication means allopathic medication through health care providers, followed by self-medication as an alternative.

Table 11 Use of Health Care Services

Medication	Number (n=175)	Proportion Percentage
Modern medication	168	96.0
Self-medication	100	57.1
Alternative Medication	40	22.8

Table 11 shows the Medication sought by the family for any latest illness during the past three months. It shows the pattern of health care practices adopted as 96% of people are adopting modern Medication as an alternative after self-care. Alternative Medication was adopted by 23%, either Homeopathic or Ayurvedic. The figure indicates that poly-practices in poly-pharmacy and polyclinics/HP/SHP/PHC/Hospital are the indicators of Rajbanshi's health-seeking behaviour.

4.5.4 Types of Modern Health Services

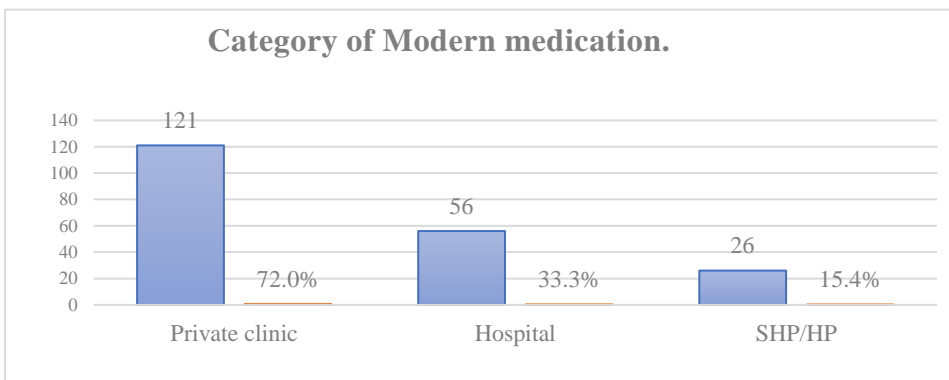


Figure 6 Category of Modern medication

In figure 6, the community out of 168 people, the private clinic was used by 72.0%, hospital by 33.3% and SHP/HP by 15.4%. In other words, people often go to private clinics rather than hospitals and health posts.

4.5.5 Categories of Self-medication

Kafle and Gartaula (1993) and Gartaula (1998) have categorized self-medication as Shamanism, Priest, Dhami-Jhakri, herbal, drug retailers, grocery, kit-bag, drug peddler, neighbour, following old medicine prescriptions etc. and except the present prescription by a qualified medical practitioner. Worship god and going to the traditional healers are accepted practices while getting sickness is common. Anybody readily does this practice herself or himself even before starting any treatment. So, Self-medication comprises Herbal, Drug retailers, Grocery, Kit bags, Drug peddlers, neighbours, following old medicine and prescription and traditional healers in the study.

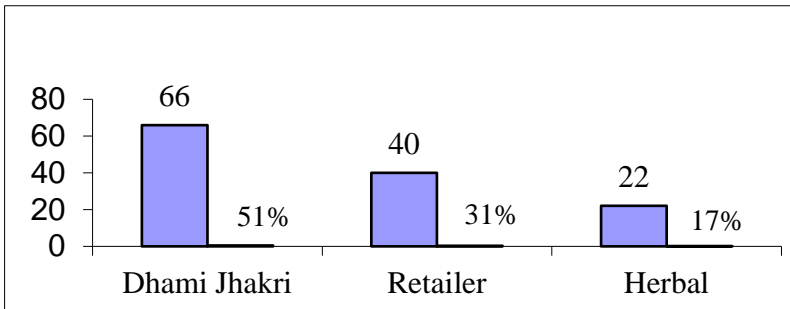


Figure 7 Category of Self-Medication

Figure 7 suggests people were found using DJ by 51% (66), retailer by 31% (40) and herbal by 17% (22) and following old medicine from prescription by 1%.(1)

Table 12 Dhami Jhakri Practices

Healing Practices.	Number (n=66)	Proportion Percentage
Phukphak	61	62.4
Worship	53	80.3
Sacrifice	25	14.2

Table 12 indicates self-medication was commonly adopted in the Rajbanshi community. Dhams/Jhakris were making Phukphak, Worship and Sacrifice. People used to go to Dhams/Jhakris/Shaman and were found still having a strong belief in their healing power. They regard DJS as a part of life; without them, their lives become incomplete and needed in every ritual. They were also familiar with the retailer's shop and used to buy drugs and prepare herbal medicine at home conventionally.

On the theoretical level, medical beliefs and practices constitute a major element in every culture; consequently, they are interested in their own right and the insights they give into other aspects of the culture they are a part of. Practically, knowledge of indigenous medical beliefs and practices is important in planning health programmes for and delivering health services to traditional people. In describing medical systems other than their anthropologists show increasing embarrassment over the problem of terminology. All terms commonly used imply a quantitative gap between "modern" medicine that is a product of indigenous cultural developments, dichotomy emphasized by contrastive terms such as "scientific" versus "primitive", "western" versus "non-western" and "modern" versus "traditional". Although the qualitative gap exists, in an era of extreme cultural relativism, many people are disturbed by terms that suggest evaluation. (Gartoulla, 1998)

In surveying the ethnomedicine practices in the Rajbanshi community dealing with causality concepts, the researcher found that only a few cognitive frameworks were necessary to explain the presence of disease. A dual division is sufficient to distinguish major categories, which may be termed personalistic and naturalistic, as Foster suggested (1978).

A personalistic system can be identified when illness is believed to be caused by the active, purposeful intervention of an agent who may be a supernatural being (a deity or a god), a non-human being (such as a ghost, ancestor, or evil spirit), or a human being (a witch or sorcerer). The sick person is a victim, the object of aggression or punishment directed specifically against him for reasons that concern him alone.

A sick person can be treated through any one of the following:

Propitiation of gods and goddesses. Propitiation or driving away the evil spirit (exorcism and witchcraft); Treatment by magic. Use of charms and amulets; and Application of empirical medicine. (a) Western medicine (b) Ethnomedicine. (Gartoulla, 1998)

The characteristics of the traditional healers in this community are found as follows: In Nepal, as in the rest of the world, there are doubts about the creation of the universe, but credit for creation is frequently

given to supernatural power, gods and goddesses. Most people, in times of trouble, turn to god for help. Blessing from the gods is always sought before commencing any new ventures.

The concept of "Atma" " (spirit or soul) is also important in understanding the healthcare practices in the communities in Nepal. If the "Atma" is disturbed, the system will be in disequilibrium with possible mental or physical stresses and strains. (Gartoulla, 19998)

Prayag Raj Sharma, in his study of the divinities in western Nepal, has found some striking features in the people's religious practices. The supreme divinities in the Karnali basis resolve themselves into five classes. In the first category come the Mastos, who are 16 in number (in the region where he carried out his study). He has not, however, mentioned that the name and number of such Masto divinities might vary because they are the clan'sclan's deities, and every family would know what Masto to its Kul devata (clan deity) or benefactor to whom references may be made if there is any cause of distress.

In the second category are several divinities whose names do not bear the Masto suffix but wield considerable power and prestige. In the third category fall the deified spirits. In the fourth category comes the female goddesses, and in the last are included Chandan Nath and Bhairav Nath, who wield much influence upon the fate of the females in particular. Sharma has mentioned that most of the supreme divinities manifest themselves through a human medium, the oracle, who, in the local parlance, is called the. The institution of Dhams is based on the principle of reincarnation. When an old Dham dies, the vacated position is filled up, after a certain time, by another person of the same family or clan group in whom the divinity chooses to reappear (autinu). (Gartoulla, 1998)

Hitchcock presents four types of spirit possession in the Nepal Himalayas: time and scope-reincarnate possession, utter possession, oracular possession and peripheral possession. (Gartoulla, 1998)

Recourse to Shamans, that the Dhams and Jhakris is a common practice everywhere and with all communities in Nepal. One of the smallest groups among the Tibeto-Burman-speaking population of Nepal is the channel of the Dhaulagiri zone. Wolf Michael wrote that they claim to be Hindus but Hinduism, then even the northern Magars, much less influences them. Among the deities worshipped by the Chantals, only a few belong to the classic Hindu pantheon, the most important, however, being the local deities like Bhume, Bara and Siddha. Witches (Bokshi, Dayani), globulin or demon-like being (Bir, Masan) and the spirits of the dead

(Moc, Prêt, Siyo) play a dominant role in the religious beliefs and observances of the Channels. (Gartoulla, 1998)

The various appellations by which shamans are called in Nepal vary from community to community, and there is a subtle difference in the practices of some of them. Such appellations are as follows: Dhami, Jhakri, Lama, Guvaju, Fedangwa and Bijuwa. Fedanwa is a shaman from the Limbu community, and Bijuwa is from the Rai community. The Guvaju are Newars, and it is noted that Guvaju is used for shamans, priests and others. But there is some interesting difference between the Dhami and Jhakris. Most importantly, the Dhami belong to Brahmin, Jaisi or Chhetri castes, whereas Jhakris do not belong to such twice-born categories. In a story, The Jhakris could not reach the heavens with the help of his incantations and magic, while Lama could achieve the same.

4.5.6 Alternative Medication.

Ritu Prasad Gartoulla has mentioned Alternative medication in a book Therapy pattern of conventional medicine with other alternative medication: A study in medical anthropology in Nepal as follows:

“Alternative medicine is a rather vague term used loosely to distinguish ancient and culturally bound healthcare practices that existed before people used Science for health matters. Some frequently used synonyms are indigenous, unorthodox, folk, fringes and unofficial healings.

Alternative medication practices have different meanings to different people. Some are inclined to include even ethnomedicine in it, while others prefer to restrict various practices excluding ethnomedicine under this category. Besides the supernatural healing practices, medications are done without contacting modern/ allopathic medical practitioners, like contacting drug retailers, over-the-counter sales, using private kit-boxes, consulting neighbours and various other legitimate concerning the supernatural realm, and resorted before contacting modern medical practitioners.

Medication practices have taken several forms in different parts of the globe. The history of modern medicine can be traced undoubtedly from the remote past and the practices evolving gradually and indigenously among various people, not only from the west alone but also from eastern societies. But one important differentiating factor has been the application of experimental logic to the modern Science of medicine. The therapeutic

intricacies are examined as to how exactly the medicine works and why they have been sought to be unearthed. In alternative medication practices, the whole channel of cause and effect relation is not sufficiently explicit, even though investigations are being conducted into some of them in recent times to reveal the inner relations, as in the case of, say, acupuncture, which has been one of the alternative medication practices evolving in China.

Acupuncture and moxibustion have been applied in China for the last 2000 years. The simplicity of their application, their minimum side effects, and their low cost and rapid effect have made to remain popular. It is pointed out that some practitioners of acupunctures still adhere strictly to traditional medical theory. In contrast, others use it empirically, without reference to the indigenous Chinese belief, and strictly by western style diagnosis and concepts of pathophysiology. Internationally there is a diversity of opinion regarding acupuncture techniques, the pre-requisite qualification of an acupuncturist, the usefulness of the notion of channels and the specificity of the acupuncture points.

Acupuncture, Unani or Chandsi medication (indigenous to eastern Bengal), like many other recent ones such as Homeopathy, have made their inroads into Nepal through the diffusion of culture. But, here, in this account of the alternative medication practices in Nepal, such items are not included because they are external influences and are by and large urban centred even now.”

Ayurvedic and Homeopathic medication has earned a good reputation through services available in the urban area only for a small number of. They believed that many modern medicines are sourced from Ayurvedic raw materials. So they were friendly in using Ayurvedic medicines. Likewise, they believed that despite its slow action, Homeopathic medicine could eliminate the root of the disease.

Table 13 Category of Alternative medication

Alternative medication (n=40)	Number	Percentage
Ayurvedic	28	70.0
Homoeopathic	12	30.0

Table 13 illustrates the categories of Alternative medicine i.e., Ayurvedic and Homeopathic. Out of the total 175 respondents, 22.8% (40) were adopting alternative medication and among them, 70.0% (28) had

adopted Ayurvedic and 30.0% (12) patients had adopted Homeopathic medication. The Remaining had gone to another area.

4.5.7 Causes of taking Services.

Some studies say that people's behaviour of taking care is mainly guided by their perceived satisfaction. Places where they get a good investigation, diagnosis and treatment, as well as good interpersonal communication, were their choice. Other determinants were distance, custom, cost and others. Patients mostly used go to a health facility with the advice of his/her family, neighbours/friends and by self-knowledge, IEC such as Radio and TV, and health workers.

Table 14 Reasons for taking health services

Reasons	Number (n=175).	Proportional Percentage.
Satisfaction	145	82.8
Short distance	49	26.2
Custom	24	13.7
Cost/ Cheap	16	9.1
Other	1	0.5

(Note: Response by duplication).

Table 14 shows why people were going to take a particular healthcare service. 82.8% of people were driven towards where they felt satisfied. The second guiding factor was short distance (26.2%) and custom (13.7%), cost (9.7%), and other 0.5%, respectively.

4.6 Referral System

4.6.1 Advice for Referral

Table 15 Advice for referral

Advice for referring	Number (n=175)	Proportional Percentage.
Family member	107	61.1
Self	80	45.7
Neighbour/ friends	16	9.1
IEC/Radio/TV	2	1.1
Health Workers	1	0.5

Table 15 indicates the contribution of advising on referral by family members. The proportion was 61.1%, self-knowledge was 45.7%, neighbour/ friends 9.1%, IEC/Radio/TV 1.1%, and Health workers 0.5%, respectively.

4.6.2 Frequency of Visits.

Table 16 Frequency of Visits

Frequency	Number (n=175)	Percentage.
Once	57	32.5
Twice	62	35.4
Thrice	26	14.8
Four times	10	5.7
Five or more times.	20	11.4

According to table 16, out of 175 patients, 57 (32.5%) patients visited once, and 35.4% visited twice for treatment. Similarly, 14.8%, 5.7%, and 11.4% of patients visited thrice, four times and five or more, respectively, for the treatment.

4.7 Satisfaction

4.7.1 Satisfied clients number

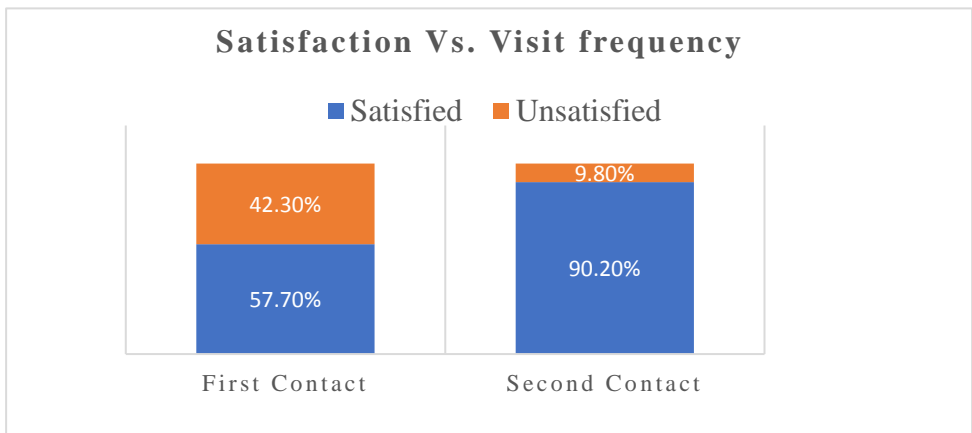


Figure 8 Satisfaction and Number of Visits

Figure 8 indicates that patients were satisfied with their second visit rather than the first visit. In their first contact, 57.7% of patients were satisfied with the treatment and 90.2% were satisfied with the second visit.

4.7.2 Expenses for Treatment.

Table 17 Average Expenses

S.N.	Topics	Amount (N.Rs.)
1	Buying drugs	598.35
2	Paying fees	201.68
3	Transportation	52.30
4	Helper	38.58
5	Other	142.77

Table 17 demonstrates an average expenditure per sick is Rs.1 031.64. However, the bulk expense was (58.0%) for purchasing drugs and paying fees (19.5%). And 5.0% for transportation, 3.7% for helpers and 13.8% for others.

The treatment Cost

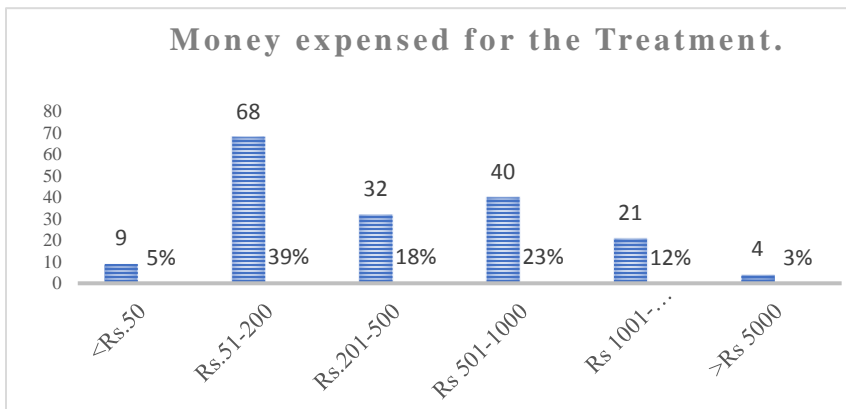


Figure 9 Treatment Cost

Figure 9 illustrates that people usually (39%) pay 50-200 rupees for their treatment. Likewise, 23% had paid Rs. 501-1000, 18% paid 201-500, 12% paid 1001-5000, 5% paid less than Rs.50, and 3% paid more than

Rs.5000. An ordinary people paid Rs. 1031.64 per sick for treatment. A bulky proportion of money is used for the cost of drugs and fees for doctors or healers. The rest of their money is expensed for helpers, transportation and others.

4.7.3 Affordability.

Table 18 Affordability

Affordability	Number	Percentage.
Yes	47	26.8
No	128	73.2
Total	175	100.0

Table 18 suggests that 73.2% of people were reportedly unable to afford the cost of treatment. Only 26.8% of people were able to afford the treatment cost. So it is striking to note that only less than one-third of people were found to be able to afford the cost of treatment.

4.7.4 Cost Bearing

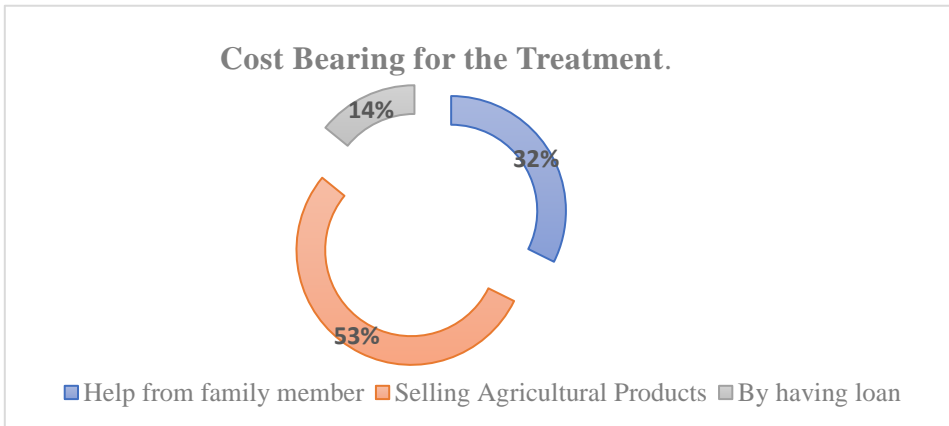


Figure 10 Cost bearing

Figure 10 suggests that 32% of people took help or borrowed from their family members. 53% sold their belongings, such as agricultural products, land etc., and 14% took loans for treatment. More than two third people were found unable to afford the cost for the accomplishment of treatment.

4.7.5 Satisfaction.

User satisfaction from service providers determines by the local people who might have taken various forms depending on who administers what medicine to whom and how. Sometimes it happens that even when modern medicine is used, it is done without the advice of a regular doctor. Such cases occurred when a person consumed medicine on his own or procured it from someone who did not possess the necessary knowledge of medicine. In such cases, it is immaterial whether the medicine administered is correct. Despite having skills and knowledge, a doctor or a paramedical could not function well in a hospital/PHC/ HP setting at desired level due to limited resources, support and the burden of work. It also plays a vital role in the satisfaction of a consumer.

There are several chances of misuse of human health resources in our health system. A Village Health Worker has training for certain preventive and promotive measures in public health areas. They are supposed to work in immunization, health education and sanitation. But people expect more during their frequent visits. So, sometimes VHW/ MCHW or paramedical provide services more than expected.

Kirana shops Keepers (Grocers) hold shops of daily use such as rice, pulse, oil etc. But they sell certain medicines such as Paracetamol, Antihelminths, Antibiotics, ointments for the eye, skin etc. It is easily estimated that there is maximum irrational use of drugs from the grocery, but it is not easy to control because many people are getting services from here.

Dhami-Jhakris is regarded as the representative of supernatural powers, and with their aid, they can cast off evil spirits that cause affliction to people. While curing the patient through some rituals and practices, they are held to be in communion with gods and goddesses.

Despite the health facilities provided by the government, more than 50% of health problems never reach health services. They are treated through self-care and plural medications based on home remedies. Other methods of unconventional treatments include commercial sales of over-the-counter (OTC) drugs, often combined with religious healing practices and culturally based treatments which are economically beneficial to the people. (Gartoulla, 1998)

4.7.6 Satisfaction with the investigation

The study noted the Client's Satisfaction with the investigation process of treatment.

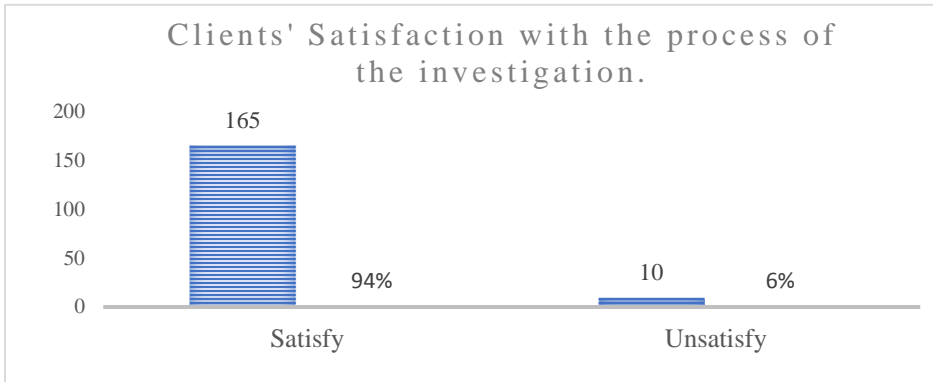


Figure 11 Satisfaction with the investigation

Figure 11 suggests 94.0% of patients were found satisfied with the investigation process during the treatment. Only 6.0% were dissatisfied with the process of investigation during treatment.

4.7.7 Usual Visit to Take Care.

The study found that people were taking services from multiple medications, such as -Modern medication, Self-medication and Alternative medication practices.

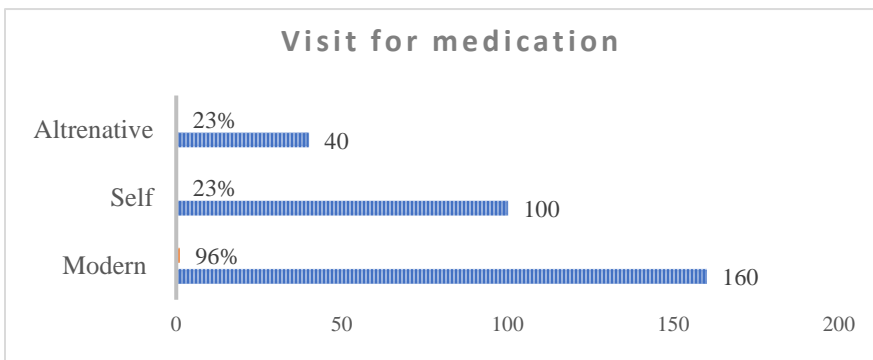


Figure 12 Usual visits for medication

Figure 12 noted the usual place to visit for 96.0%(168) people were modern medication, self-medication for 57.1%(100) and Alternative medication for 22.8%(40). (N=175).

4.7.8 Satisfaction as perceived

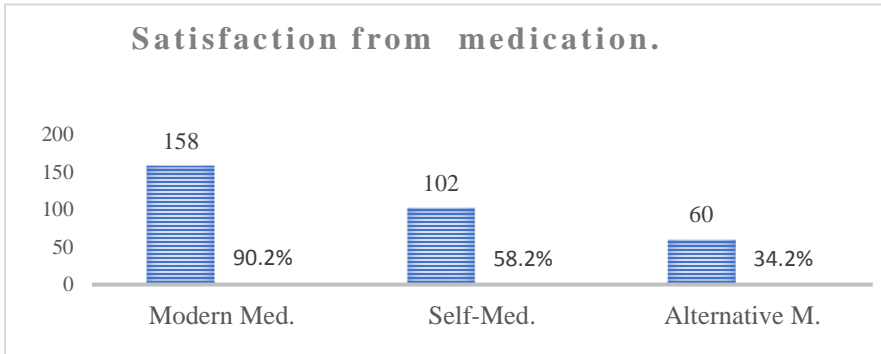


Figure 13 Satisfaction as perceived

Figure 13 shows the Satisfaction as perceived from the medication practices adopted. Out of 175 respondents, 158 (90.2%) were satisfied with modern medication, 102(58.2%) satisfied with self-medication and 60 (34.2%) were satisfied with alternative medication. It was due to the cure rate, low cost, provider behaviour, free medicines, and good counselling, which are the causes for Satisfaction.

Users are satisfied with the following points.

Medicine facility, experienced service provider, emergency services, quick services, previous experience, quality of care, better examination, good behaviour of service provider, proper treatment, proper advice, Female service provider for female cases, service availability, laboratory facility, x-ray facility etc.

Users are dissatisfied with the following points.

Irregular presence of service providers, Physical facility, water, sanitation, expensive medicine, No lab, No latrine, No x-ray, Wrong behaviour of service providers, No home visits, No surgical facility, No specialist service, No transportation service, necessary medicines is not available etc.

4.7.9 Satisfaction with medication based on Education.

Table 19 Satisfaction with medications

Medication	Educated (n=45)	Uneducated (n=130)	P - Value
Modern	41 (91.1)	111 (85.3)	0.3271
Self	14 (31.1)	45 (34.6)	0.669
Alternative	42 (93.3)	39 (30.0)	0.0000

Table 19 shows no difference between educated and uneducated in using modern medication that is statistically insignificant ($P=0.03271$). Similarly, there was no difference between educated and uneducated in adopting the statistically insignificant self-medication ($P= 0.669$). But educated were adopting more alternative medication practices than the uneducated, which is statistically highly significant ($P=0.0000$).

4.7.10 Satisfaction from medications based on economic status.

Table 20 Satisfaction with the medication based on Economic condition

Type of Medication	Satisfaction			
	Poor (n=107)	Medium (n=22)	Rich (n=46)	P- Value
Modern	99 (92.5%)	18 (81.8%)	41 (89.1%)	0.289
Self	42 (39.2%)	5 (22.7%)	13 (28.2%)	0.200
Alternative	56 (52.3%)	10 (45.4%)	36 (78.2%)	0.005

Table 20 demonstrates that there was no difference among poor, medium and rich in the use of modern medication that is statistically insignificant ($P=0.28947$). Similarly, there was no difference among different strata in using self-medication that was statistically insignificant ($P=0.2000$). But rich were adopting alternative medication more than other economic strata, which is statistically significant ($P=<0.005$).

4.8 Findings from Focus Group Discussion

The situations created during different Focus Group Discussions with Rajbanshi people in Katahari and Baijanathpur VDCs of Morang district facilitate the study to experience the real situation by taking their views, by interacting with the groups. So, the discussions helped to collect their ideas about their health-seeking behaviours. They expressed their views regarding modern, self and alternative medications. They were also eager to express their demands to the government and the Institute of Medicine. There were found different NGO/INGO interventions in these VDCs. Many people said that they have already taken different pieces of training. They also want more health training, they expressed. Here are some views regarding our health system which are somewhat critical too. The researcher has felt that these FGDs were not only useful for collecting or exploring things but also useful in the evaluation of data collection as well.

Total FGD = 10

Table 21 Composition of Focus Group Discussion

Group No.	Male	Female	Total
1	8	0	8
2	0	8	8
3	3	5	8
4	6	2	8
5	7	1	8
6	1	7	8
7	6	2	8
8	5	3	8
9	2	6	8
10	3	5	8
Total	41	39	80

Point No.1. Could you please explain your views on medication patterns in your village?

Response	General Responses
1	We use modern, self and alternative medications.
2	Modern medication is effective but also going to be expensive.

3	Self-medication is cheap and common. It comes in the first step. If it does not cure, we go to the clinic.
4	Ayurvedic drugs and doctors are cheap– No side effects.
5	Homoeopathic drugs are slow in action but eliminate the cause. Drugs and fees are cheaper.

Point No.2.Describe consultation practice in your village.

Response	General Responses
1	Our regular visits are to a private clinic because it is easy to access all the time.
2	First, our practice is self-medication and modern medication.
3	First, our practice is self-medication; after that Ayurvedic or homoeopathic.
4	Health posts and hospital services are expensive and not so good but we use them.
5	Family members and sometimes Faith healers decide where to go to cure.

Point No.3. People's faith in Faith healers and their impact on health.

Response	General Responses
1	We partly believe in faith healers. It can make us free from fear and tension only.
2	We believe that faith healers can cure mental diseases.
3	They are decreasing in number, so the government should train a faith healer.
4	We believe them because they need in our every ritual.
5	Some faith healers are cheating us, but we cannot ignore them.

Point No.4. People's faith in traditional healers and health impact.

Response	General Responses
1	We partly believe them. But we need them urgently.
2	We take their advice, they can make our fortune good.
3	Their number is very few, so we cannot say.

4	They are our traditional healers. Today they are our service/ advice providers.
5	We need to ignore their healing because we have modern medicine in easy access.

Point No.5. People's faith in Ethnomedicine and their impact on health.

Response	General Responses
1	It is disappearing day by day. It is slow in action.
2	It still exists. We need to preserve it. It works for many things.
3	Ethnomedicine is more difficult to access today rather than modern medicine.
4	We should try this because it is cheap and if not get well contact the modern, alternative care.
5	It takes time, so we have no time to go to ethnomedicine. Modern medication-quick

Point No.6. People's faith in Supernatural beings and their impact on health.

Response	General Responses
1	We partly believe them.
2	We believe it, but we cannot say more.
3	We cannot say about it.
4	It is responsible for sickness, but we are not sure.
5	We ignore supernatural beings because it is not scientifically proven.

Point No.7 Source of information for medication.

Response	General Responses
1	Radio, TV, Health worker, friends
2	Family member, neighbour, Faith healer, FCHV
3	Friends, HP, Hospital, teacher, students, radio, TV
4	Family member, neighbour, Faith healer, TV, Radio
5	Radio, TV, Health worker, friends, neighbour.

Point No.7 Any other suggestions/ information on the health care practices.

A middle-aged gentleman at Katahari VDC(Group No.6) said: *Modern medication is good, but it has many side effects.*

Another gentleman said (Group No.7): *Since doctors are not looking as good at hospital and health posts as in their private clinics, they should not be allowed to open their private clinics by the government.*

Middle-aged women at Baijanathpur VDC (Group No.2) said: *Drugs and doctor's fees are much more expensive. So, drugs should be available at a lower price at clinics, shops, HP and hospitals.*

A young man at Katahari VDC (Group No.9) said that *Health Post's doctor does not examine us properly, so s/he cannot diagnose the disease. Therefore, it isn't very helpful to visit health posts.*

A woman (Group No.8) *The same doctor examines well in his clinic. We do purchase drugs either in the health post or in his clinic. So, I prefer to go to a private clinic.*

An older man (group no.4) said; *Dhami/ Jhakris are needed in every ritual, and they can do something for our ailments. We always go to DJ for almost all health problems. If he gives suggestions, we seek care such as HP, hospital, clinic or else. They are accepted as a part of our culture till now.*

But a middle-aged gentleman (group no. 5) said: *DJ is cheating us. They cannot cure our disease. They can only make us free from fear and free of tension.*

A middle-aged woman at Baijanathpur asked: *Since the Dhami/Jhakris' numbers will decrease today.*

Dhami/Jhakris also should be made available by the government.

A gentleman (group no.10) said that *they needed to be trained and recognized by the government.*

A young man (group no 5) said: *I am using Homeopathic drugs from Biratnagar. It can eliminate the root cause of the disease, so it cannot let the disease relapse again.*

An older man said (group no.4) that: *I am using Ayurvedic medicine. Ayurvedic is the main source of drugs in modern medicine, so I prefer Ayurvedic medicine.*

Another gentleman (group no.1) added that *it takes a long time to cure, so it is useless in an emergency.*

Expectations of the Participants and their Suggestions

1. Provision of cheap drugs to be provided for them while in treatment.
2. Provision of free-mobile health camps.
3. Training and health education programs are needed for Rajbanshi.
4. 4. Such provision should be made that either Hospital doctors/paramedics should see patients in their clinic or Government doctors/ paramedical should not be allowed to see patients in Private clinics.
5. Dhami/Jhakri should be provided training and recognized by the Government. After that, the Government should make them available in the community.

CHAPTER V DISCUSSION

Rajbanshis live in Morang and Jhapa districts in Nepal. Rajbanshi ethnic in Katahari and Baijanathpur VDC were found to have a literacy rate of 65% in the sample taken. The principal occupation is agriculture. Most people fall in the category of having no land to less than 2 bighas. The average family size is 5.76 persons. Investigators interviewed mostly the head of the 175 households made in two VDCs. And 61% of males and 39% of females reported being sick.

A common type of ailments was reported, such as headache, body aches, weakness (50.8) and then ARI (44), fever (30.8), Eye/ENT (18.8), and diarrhoea (13.7) were reported, respectively. The distribution of reported illness was highest among those over 66 years of age than among 55-65 and 46-55 years of age, respectively.

Private allopathic clinics conducted by paramedics were abundant in the local market, which was familiar in the community. So, minor injuries and ailments were being treated there. People were getting satisfaction through private clinics (72.0%) rather than from nearby situated Sub-health posts (15.4%). A relatively larger number of people went to private allopathy clinics where they got good treatment in terms of examination, counselling and drugs, which satisfied them. It was noted that despite being easy access the majority of people were found unsatisfied with the treatment given by Sub-Health Post. A large number of people were reporting that there is no worthwhile going to Health posts. Since they don't examine properly, they cannot diagnose the disease. Consequently, treatment becomes worthless. It was to waste of time and money.

They also have the Koshi Zonal Hospital facility for Emergency and special services. People who need sophisticated facilities such as Emergency, obstetrics and chronic cases used to go to higher service centres at Biratnagar, Dharan, Kathmandu and India.

Likewise, people were found to be deeply attached to their Self-medication practices. They readily go to Dhami/Jhakri/Shaman due to cultural factors and satisfaction. And sometimes lack of adequate money to pay for modern medication also drives self-medication. Since cultural belief was deeply rooted, people would feel oneself incomplete without the presence of Dhami/Jhakri/Shaman or Self-medication in society. Investigator felt that even people who blamed Dhami/Jhakri as merely cheating in the name of healing, we're also admitting that they could make us at least free from tension and fear.

There was no difference in the use of modern medication among different economic levels that is statistically insignificant ($P=0.3871$). The study found that the poor adopted a highly effective practice of self-medication, i.e., statistically significant ($P=0.0160$). Likewise, the rich are largely adopting a statistically highly significant alternative medication ($P=0.0000$).

It was found that there was no difference in the use of modern medication between the educated and uneducated, which is statistically insignificant ($P=0.3753$). But the use of self-medication by the uneducated was significantly higher than the educated, which is statistically highly significant ($P=0.0000063$). And no difference in the use of alternative medication between educated and uneducated is statistically insignificant ($P=0.2635$).

They were found familiar with going to EPI-Camp (79.4%) to get a vaccination for their children. They are also familiar with FCHV and recognize her services. Most people know their FCHV (50.2%) and used to take service from her. On the other hand, more than 89.2% population was found still unknown to MCHW, TBA and PHC-ORC and its services.

There was no difference between educated and uneducated in using modern medication that is statistically insignificant ($P=0.03271$). Similarly, no difference between educated and uneducated in adopting self-medication is statistically insignificant ($P=0.669$). But educated were adopting more alternative medication practices than the uneducated, which is statistically highly significant ($P=0.0000$). It was noted that there was no difference among poor, medium and rich in the use of modern medication that is statistically insignificant ($P=0.28947$). Similarly, there was no difference among different strata using self-medication that was statistically insignificant ($P=0.2000$).

But rich were adopting alternative medication more than other economic strata, which is statistically significant ($P<0.005$). They were also found to have critical perceptions regarding modern medication

practice, as it is expensive and doctors and paramedics are not treating patients like their private clinics. Self-medication practices are common for minor and common types of ailments. And it is an integral part of their culture. Likewise, they are relatively less familiar with Alternative medication because of its unavailability locally. But they keep believing in its usefulness for chronic diseases and assume its potential to eliminate disease slowly.

An average treatment per case cost is Rs. 1031.64 (SD=6). 73.1% of patients reported being unable to afford the expenses for treatment. They had taken either loan (14%) or had to sell land, animals, grains or personal belongings (53%). The bulky proportion (57.8%) of expenses fell on buying drugs and fees (19.55%). After that, for transportation, 5%, helper, 3.74%, and others, 13.84%. Therefore, the concern about the unaffordability of treatment costs for modern medication is striking.

1. Rajbanshi people go for health care where they are supposed to get satisfaction and feel reliable. So, they are choosing medication was mainly influenced by their perceived satisfaction. The satisfaction was regarding redness, investigation, interpersonal relationships, and treatment. Patients were usually visiting more than one time.
2. The second visit provided more satisfaction. Similarly, other guiding factors were distance, customs, cost etc. Family members and self-knowledge were driving forces to adopt certain medications. People also expressed the need for the service of Dhami/Jhakris, training for Dhami/Jhakri and government recommendations.

CHAPTER VI CONCLUSION

The conclusions are drawn from the study's objective, findings, and analysis.

1. The major occupation of Rajbanshi in Katahari and Baijanathpur was agriculture. And others were labour-work, business, service etc.
2. Most people fall in the category of having no land to less than 2 bighas. A common type of ailments was reported, such as headache, body aches, weakness (50.8) and then ARI (44), fever (30.8), Eye/ENT(18.8), and diarrhoea (13.7) were reported, respectively. The distribution of reported illness was highest among those over 66 years of age than among 55-65 and 46-55 years of age, respectively.
3. People were found using Modern medication equally. Higher use of Self-medication by the poor was significant ($P=0.0160$). Similarly, higher use of alternative medication by the rich was statistically highly significant ($P=0.0000$).
4. The literacy rate in the sample was 65%. Among Rajbanshi samples, 29% were educated (above SLC). Uneducated people using more self-medication were found statistically highly significant ($P=0.0000063$).
5. More than 90% of Rajbanshi in these two VDCs had modern health facilities within 30 minutes of distance. Utilization of PHC services: They were found familiar with going to EPI-Camp (79.4%) to get a vaccination for their children. Half of the people know their FCHV (50.2%) and take service from her. On the other hand, more than 89.2% population was found still unknown to MCHW, TBA and PHC-ORC and its services.
6. Self-medication- Dhami/Jhakri/Shaman were the main service providers of Self-medication. They used to Phukphak, worship, and sacrifice 62.4%, 80.4%, and 14.2%, respectively. Retailers and herbal were also common in this community.
7. Causes: People were mostly guided by their perceived satisfaction (82.8). Other determinants of choosing certain practices were distance, custom, cost etc. Family members and

self-knowledge played the driving role in deciding the possible options.

8. Visits: Most patients go more than once to take health care, and their second visits provide significant satisfaction.
9. Cost: The proportion of people paying between Rs.51-200 was 39% of the sample. But the average expenditure per case was Rs. 1031.64 (i.e. mean, and SD=6) for a treatment. It was reported unaffordable for more than 73% of people, so they take loans or sell their belongings to accomplish the treatment. Most of their expenses go to buying drugs and paying fees. The rest portion expensed for transportation, helper cost and others.
10. Satisfaction: Rich was satisfied with alternative medicine, which was found statistically significant (0.0050). Educated was found satisfaction with alternative medication was highly significant (P=0.0000).

5.2 Recommendations:

The following suggestions are made in light of the findings:

1. Since most of the poor people go for self-medication and the private clinic was perceived to be expensive, the personnel of the self-medication or service provider such as Dhami/ Jhakri/ Shaman, the retailer needs to be oriented on the referral system. Since 73.2% of people cannot afford treatment, they require free mobile health camps for the poor.
2. Since 89.2% of the population was unknown to MCHW, TBA and PHC-ORC services, they require specific training and awareness programs for service providers and users.
3. The suggestions from the qualitative study match those from the findings from qualitative analysis, and thus the following points are made for the recommendation. Since consumers were reporting that doctors or health workers check up a patient very well in the clinic than in an HP/ SHP/ Hospital, so they preferred to go to a private clinic than HP/SHP. Some specific rules were expected from the respondents to change the situation from the government.

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Appendix

Appendix A

Questionnaire

Tribhuvan University
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A Dissertation in partial fulfilment of the requirement for the Master in Public Health (MPH).

Topic:- Health Seeking Behavior of Rajbanshi Community in Katahari and
Baijanathpur VDCs of Morang.

Questionnaire Form.
2057/ /

Name of Interviewer:

Date:

Name
Religion.....

Demographic No.

Name of the Interviewer:

Date: 2057/ /

Name of the Respondents:

Age: ... Sex: ...

Education:

Family Number: ...

Dist..... VDC..... Ward No..... Village Name:

Demographic Information.

Household No...

S. N.	Family members	Relationship with HH	Age (A)	Sex M/F	Education (B)	Profession. (C)	Property (D)	Illness within 3 months. Y/N	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Note: A= (a) 0-10 (b) 11-20 (c) 21-35 (d) 36-45 (e) 46-55 (f) 56-65 (g)66-over. B= (1) Illiterate. (2) Literate. (3) Primary (4) SLC (5) IA (6) BA and over. C = (1) Agriculture (2) Business. (3) Service. (4) Dependent. D = Land (1) 0-2 bigahas, (2) 2.1-4 bigahas (3) 4 bigahas and over.

Appendix-B

1. What illnesses or diseases have you got during the last three months?
(serially)

1.....

2.....

3.....

2. What you did do?

1. Self-medication

2. Modern medicine

3. Alternative Medicine

4. Nothing done

2.1. If self-medication which of the following:

1. Shaman/ priest/ Dhami/Jhakri.

2. Herbal/root/grass/plant

etc.

3. Drug Retailers.

4. Grocery.

5. Kitbag.

6. Drug peddler.

7. Neighbour.

8.

Following

old

medicine.

If any other.....

2.2. If modern medicine which of the following?

1. HP/SHP

2. Hospital.

3. Private clinic/Nursing home

4. Other.....

2.3. If Alternative medicine which of the following?

1. Ayurvedic.

2. Homeopathic.

3.

Other.....

3. What was the total process that your consulted unit followed?

.....

.....

.....

...

Appendix-C

3.1. When you visited the Shaman/Dhami/Jhakri/priest what he did?

1. Phukphak.
2. Worship.
3. Sacrifice.
4. Other.....

4. Why did you visit /do so?

.....

4.1. What factor influenced you to go there?

1. Quality/Satisfaction
2. Near.
3. Cheap.
4. usual practice.
5. Other.....

4.2. Were you satisfied with the care's investigation process?

1. Yes.
2. No.

Why

5. Were there any more visits to another place?

1. Yes
2. No

5.1. If Yes, Where?Why.....

5.2. How many times you visit: -

6. How much money you did expenditure on sickness?

1. Less than Rs.50.
2. Rs.50-200
3. R.201-500.
- 4 Rs.501-1000
5. 1001- 5000
6. Rs. 5001 and over

7. What was the cost?

1. Transprtation.....
2. Helper.....
3. Medicine.....
4. Any other.....

8. Could you afford that cost?

1. Yes
2. No

8.1. If No, how did you manage the cost?

1. Self had
2. Loan
3. Selling
4. Other.....

9. Were you satisfied with the first contact?

1. Yes 2. No

Why

10. If had the second contact; were you satisfied?

1. Yes 2. No

Why? ...

Appendix-D

1. Who advised or referred you to go to take service for sickness?
.....

2. your mostly first visit to health care is:
.....

3. Are you satisfied with Health workers/Doctors or with treatment?

1. Yes 2. No

Why

4. Are you satisfied with Shaman/Dhami/Jhakri/priest etc.?

1. Yes 2. No

Why

5. Are you satisfied with Ayurvedic/Homeopathic doctors or health workers?

1. Yes 2. No

Why

6. Did you take service from: -

- | | | |
|--------------------|--------------|------------------|
| 1. FCHV | 2. TBA | 3. MCH Worker. |
| 4. VHW | 5. EPI-Camp. | 6. PHC-ORC Camp. |
| 7. Mother's Group. | | |

7. How far is your nearest Sub-Health Post or Health Post?

1. Less than 30 mins. 2. More than 30 mins.

8. Could you please explain your views on this?

18.1. Medication pattern at your village
.....

9. Consultation practices at your villages.
.....

10. People's faith with and their impact on health.

(a) Faith Healers.
.....

(b) Pandit/lama/guvaju/Astrologer.
.....

(c) Ethnomedicine.

.....

(d) Supernatural beings.

.....

11. Sources of information for medication.

.....

12. Any other suggestions/ information on the health cares practices?

Appendix - E

Guidelines for Focus Group Discussion.

1. Could you please explain your views on medication patterns in your villages?
.....

2. Describe consultation practices in your village.
.....

3. People's faith with and their impact on health.

(a) Faith Healers.
.....

(b) Pandit/lama/guvaju/Astrologer.
.....

(c) Ethnomedicine.

(d) Supernatural beings.
.....

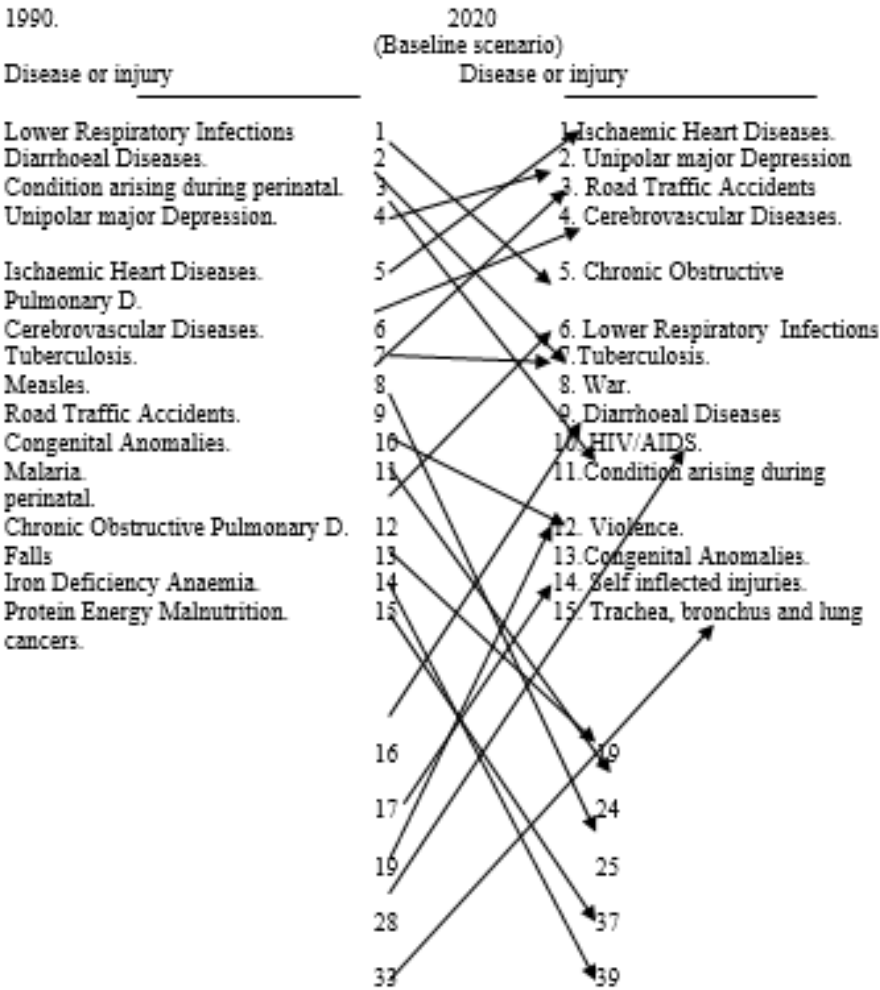
4. Sources of information for medication.
.....

5. Any other suggestions/ information on the health cares practices?

Appendix-F

Global Situation. Changes in the rank order of diseases. (World Bank)
Changes in the rank order of disease burden for 15 leading causes, world, 1990 -2020.

Disease burden measured in Disability-Adjusted Years (DALYs)



So, this changing pattern of diseases easily affects the health system, Manpower, Financial as well as technology of a country. It is a great burden and challenge for the poor country of Nepal.

About Author (updated)

Introduction



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Education

- PhD in Psychology (TU/IOHSC),
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- Master in Nepali language literature and Culture (TU/IOHSC).

Career He worked for the Ministry of Health and Population of Nepal for three and a half decades in the District Public Health Administration, primarily as the District Public Health Officer. He conducted his research and wrote papers and books. His pen is also well-known in Nepali literature and music, where he has published books and CDs.

Publications

RESEARCH ARTICLES ON CULTURE

1. Review of 'Madhesh' Definition Found in the Nepal Academy Dictionary. Global Journal of Research in Humanities & Cultural Studies: 2 pp. 119-123 (4). DOI: [10.5281/zenodo.6792441](https://doi.org/10.5281/zenodo.6792441)
2. The Philosophical Analogy of the Saksak Mundhum to Greek Mythology of Genesis Man's Ages and Its Allegorical Notation. IAR Journal of Humanities and Social Sciences; 2022; 3(3): 24-29. DOI: [10.47310/iarjhss.2022.v03i03.004](https://doi.org/10.47310/iarjhss.2022.v03i03.004)
3. A Critical Review of the Evolution of Language Families in Nepal. [Global Journal of Research in Humanities & Cultural Studies, Volume 02 | Issue 02 | March-April | 2022](#)
4. An Analysis of the Kirat Limbu Traditional Beliefs and Culture. [Global Journal of Research in Humanities & Cultural Studies, Volume 02 | Issue 01 | Jan - Feb | 2022](#)
5. Tungdunge Mundhum Establishes a Link Between the Sen and the Samba Dynasties. IAR Journal of Humanities and Social Sciences; 2022; 3(1): 1-10. DOI: [10.47310/iarjhss.2022.v03i01.001](https://doi.org/10.47310/iarjhss.2022.v03i01.001)
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11. An Overview of the Association Between the Myths and Proof of Lepmuhan Mundhum and Matsya Purana. Journal of Global Literacies, Technologies, and Emerging Pedagogies Volume 5, Issue 2, November 2019, pp. 905-921. ISSN: [2168-1333](https://doi.org/10.47310/jiarjhss.v02i03.001)
12. Culture and Health: The Unifying Aspects of Cultures [SECTION] TRANS. INST-Internet-Journal for the Humanities, [INST-Conférence 7.-9.11.2003](https://doi.org/10.47310/jiarjhss.v02i03.001)

• **BOOKS ON PUBLIC HEALTH**

1. Traditional and Modern Health Care Practices and Effects on Rajbanshi, 2016.
2. Health Seeking Behaviour of Rajbanshi in Morang, Nepal, 2001.
3. Assessment of Health Improvement Program, 2003 (Co-writer)
4. *Janaswasthya Abhyas ra Anubhav* (Collection of Public Health Articles in Nepali) 2017.
5. *Janaswasthya Paataa Baataa Ra Anubhuti* (Collection of Public Health Articles in Nepali) 2006.
6. *Janaswasthyaka Sawaalharu* (Collection of Public Health Articles in Nepali) 2007.
7. *Khotangko Swasthya* (District health profile of *Khotang* which was starting in health sector, 1998.
8. Edited Annual Reports of Eastern Regional Health Directorate Dhankuta (2000 to 2003) and Annual Reports of District Public Health Office Morang/ Jhapa (2004 to 2013).

• **BOOKS ON CULTURE**

1. Reviewing Tungdunge Mundhum, 2020
2. Kirat Limbu Culture: An Investigation into Samba Phyang, 2023

• **BOOKS ON LITERATURE**

1. *Jeewan Mero Sabdkoshma*, an anthology of poems, 2006
2. *Bich Batoma Byujhera*, an anthology of poems, 2008
3. *Yatra Aadhaa Satabdiko*, an anthology of poems, 2011
4. *Chitkaar*, Muktak, short poems, 2012
5. *Sahidlaai Salaam*, Lyrics, 2010
6. *Mann Ra Maato*, Lyrics, 2016
7. *Manko Majheri*, Essays, 2007
8. *Samayako Swad*, Essays, 2013
9. *Life in My Dictionary*, Poems, 2020

10. The Mind Canvas, Essays, 2021
11. Jokhanama Vartaman, Poems, 2021
12. Self-Reflection at the Moment, Poems, 2022
13. Sikkaka Duvai Pataa, Essays, 2022
14. Both Sides of Coins, Essays, 2022

• MUSIC ALBUMS

1. *Deshko Maya*, Collection of Patriotic songs, 2010
2. *Hami Pahile Nepali*, Collection of Patriotic songs, 2013
3. *Lukeko Rahar*, Collection of Ghazal Album Audio, 2011
4. *Amulya Jiwan*, Collection of Modern songs, 2012
5. *Bahaar Sanga*, Collection of Modern songs, 2016
6. *Himalaima Hiun*, Collection of Folk Songs, 2014
7. Video Albums '*Pratibimba*' Series-1 to 4 is released.

Awards and Felicitations

1. Nepal Vidhya Bhushan 'Ka' – 2015 (2073 VS)
2. First prize won in First Online Webcam World Poem Competition- 2008 (2064 VS)
3. Gorkhadacchinbahu medal 1991 (2047 VS).
4. Babar Sing Thapa Memorial Prize 2008 (2064 VS)
5. Mohan Regmi smriti Banni Puraskar 2006 (2063 VS)
6. Byathith Kavya Banita Puraskar- 2013 (2070 VS)
7. Jayandra Prasai Smriti Sahitya Sanman- 2008 (2064 VS)
8. Udayananda Muktinath Aryal Sangeet Pratibha Puraskar- 2011 (2068 VS)
9. Bhadra Ghale Ghamansing Sahitya-Kala P 2014 (2071 VS)
10. Nawaranga Sahitya Sanman, Jhapa, 2007 (2063 VS)
11. Krishna Prasad- Khagendra Kumari Bhandari Sahitya-Kala Samman- 2018 (2075).
12. Ganga Bhadrashila Smriti Puraskar Gargashree Sanman- 2016 (2073 VS)
13. Hongkong Nepali Federation Felicitations, 2013 (2069 VS)
14. Lekhnath Pustakalaya Sanman- 2012 (2069 VS)
15. Pallav Sahitya Sanman- 2009 (2066 VS)
16. Nateswar Nrityakala Pratisthan Sanman- 2006 (2063 VS)
17. Natyeshore Sanman, 2006 (2063 VS).
18. Dirgha Rana Samundra Bam Samman, 2013
19. Organizations like *Sparsha Nepal* 2011 (2068 VS) and *Kirat Yakthung Chumlung* Morang Nepal 2011 honoured Nawa Raj Subba (2068). Similar letters of commendation were written by *Hangpang Sewa Samaj* in Kathmandu in 2007, *Birateshwar Briddhashram* in Biratnagar in 2013, and Pathari-Sanischare Municipality in Nepal in 2018. (2075).

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